THE CANADIAN NURSE

A MONTHLY JOURNAL FOR THE NURSES OF CANADA PUBLISHED IN ENGLISH AND FRENCH BY THE CANADIAN NURSES' ASSOCIATION

VOLUME 56 NUMBER 8

MONTREAL, AUGUST 1960

FAITH AND BEGINNING

THE PRESIDENTIAL ADDRESS mentioned on your program seems to refer to something rather formal and learned. However, I wish to inform you immediately that what I prefer to call a rendering of accounts will be neither formal nor learned. I have had the occasion to listen to many presidential addresses in my career. Some I have found to be masterpieces of rhetoric; others merely made me aware that the president should have been a statistician. There were those that took you back into the far-away past — not to measure the progress, but merely to dwell on an epoch the main charm of which seems to have been the contrast with the present state of affairs. One is tempted to imitate a colleague who recently stated very emphatically that she would not make a presidential address but because there are executive secretaries to keep presidents in line with the by-laws, she prudently went on to do her duty and so shall I.

Being elected the president of a national association is indeed an honor but the mandate that is given with the title carries a great many responsibilities. It is only fitting that the president should render an account of her stewardship.

This biennium was placed under the egis of Faith. Looking back over some of the accomplishments of the last two years we find many reasons to take comfort in the fact that faith invested

(G. Carpenter)

ALICE GIRARD

in Canadian nurses has brought many rewards. The Pilot Study on the Evaluation of Schools of Nursing, which is without any doubt the main achievement of this biennium, economically speaking at least, was a pure act of faith since the lack of funds for such an undertaking was just as acute two years ago as it was in 1946 when the general meeting of this Association did not deem it possible to implement the Executive Committee's recommendation for the initiation of "a plan of action on accreditation as soon as possible." You will hear through other reports on this subject of the splendid manner in which nurses responded to the confidence placed in their generosity and understanding because they knew that the time was ripe for such a Study and that there should be no further delay. Many provincial associations, already burdened with financial problems stemming from budgets strained by the purchase or construction of new headquarters, did not hesitate to back this project to the limit of their financial capacity.

No less inspiring was the act of faith on the part of all those who so heartily endorsed this project, knowing only too well that its implementation would require unceasing efforts if they were to reach a goal so long desired but, for most, so difficult to attain.

I add nothing to your knowledge when I say that the success of this project is due to the wonderful qualities of the person we were fortunate in having as its director. I pay tribute to the fine leadership Miss Mussallem gave to those who worked with her all through the various stages of the study, as well as to the understanding, friendliness and warmth which she gave so abundantly to all those with whom she came in contact during her visits to each province.

Another milestone which must be recorded among the highlights of this biennium is the attainment of a goal first envisioned some years ago by the capable editor of our own journal, *The Canadian Nurse.* Today, every nurse who is a member of this Association is also a subscriber to our journal through her provincial association registration fee. This was no small task in itself but to culminate this achievement we have also graduated into the multi-language class — the French-speaking nurses can now read in their own language the same journal *L'Infirmière Canadienne.* Results such as this do not happen without a great deal of planning, of persuasion, of give and take. In my opinion, one of the best signs that we are a mature organization is the fact that this has been possible. It is with great joy that we now feel this sense of togetherness in our goals, especially at a time when some countries are deploring narrow-mindedness and prejudice. We can be justly proud of the unity and strength we are achieving.

In the last two years we have seen the development of governmental plans for hospital insurance, with every province but one cooperating, and this one making valiant efforts to catch up with the others in the very near future. It is inevitable that plans of such magnitude could not be implemented without a great deal of re-evaluation of objectives and methods on the part of all disciplines concerned. Nursing, which had already started its own soul-searching and self-evaluation, saw its thinking crystallize in the form that was urgently needed to seek answers to some of the burning questions posed by the administrators of these projects. Recognizing the urgency of providing suitable answers a CNA Research Committee was formed. It has not yet produced the answers because research is a painstaking process which needs time, know-how and money. The lack of this last element (the committee was approved after the budget was voted!) has certainly slowed down the tempo of progress because it must be possible to meet to work efficiently together, especially in the early stages of a program. However, the committee has started the research index. It has made a thorough review of all projects directed to it. It has assigned priorities and redistributed some studies to standing committees or provincial associations who seemed to have adequate and appropriate resources to conduct the research. Most of the more urgent projects directed to the Research Committee hinged on such fundamental questions as: What is nursing? Is what we call professional nursing today truly professional and if not, what do we want it to be? What system

of nursing education should we favor and based on the findings, what changes are needed in nursing service? If the recommendations of the Pilot Project on Evaluation of Schools of Nursing are accepted by the membership of this association a uniform approach to the answering of these questions would be a natural outcome.

In relation to governmental hospital insurance plans, it has been our privilege during this biennium to present two Briefs. The first was submitted to the Minister of National Health and Welfare as an outcome of a visit made to the Minister for the purpose of paying our respects and of discussing current affairs pertaining to nursing. This Brief, presented in February 1959, dealt with financial assistance for nursing education. Its presentation to the Dominion Council of Health led to an invitation to meet in November of the same year with the Advisory Committee on Hospital Insurance at which time we presented the second Brief. The latter contained suggestions for the organization and financing of hospital schools of nursing. It is encouraging to report that at both of these meetings we received a warm welcome and were given a great deal of time after the presentation of the Brief for informative discussion.

Another event that is worthy of mention is our venture into the field of extension courses. With the financial assistance of the Kellogg Foundation, and jointly sponsored by the Canadian Nurses' Association and the Canadian Hospital Association, we are developing a program of Nursing Unit Administration through home study and intramural sessions. The outline of the course will be approved by the two responsible organizations; lessons will be tested in pilot studies. The selection of applicants is expected to be completed by next June. It is our hope that the course will begin in September, 1961 in English and in French by September, 1962. We have been fortunate in obtaining for this experiment the services of a well qualified nurse, Miss Kathleen Ruane, who will bring experience and enthusiasm to this project.

We look upon this course as a means of fulfilling a need in an area where needs are great. We have approximately 7000 head nurses in our Canadian hospitals, the vast majority of whom will not be able to attend universities for advanced preparation. Though this course will cover only one segment of the functions of a head nurse, it is expected that institutions and provincial nursing associations will continue, through institutes and in-service programs, to help these nurses to become better equipped for what is considered as one of the most important positions in the hospital.

After this cursory review of the state of affairs in the field of nursing at home, I would like to share with you some of the impressions gained by attending the meeting of the Board of Directors of the Internation Council of Nurses held in Helsinki last summer. One is impressed with the prestige that Canadian nursing seems to command among the nurses of the world. This we owe to a number of leaders in Canadian nursing who, at various times and in various ways, have made outstanding contributions in the international field. Being exposed to the problems that confront an international association is an education in itself and at times a painful one. It is a great responsibility for your president to vote on your behalf on such issues as racial prejudice or the barring of member associations, when it is so difficult to determine objectively the degree of responsibility that is applicable to the association, how much to the political government. On the other hand, it is pleasing to observe how the ICN is growing in influence. Two of its newest features will be the appointment of a consultant on the economic security of nurses and the inauguration of the new Student Nurses' Unit.

In considering the growth and development of the ICN we must not lose sight of the fact that, numerically, the CNA is the third largest member association. If we expect to retain our prestige and to play the role which is befitting our rank in this association, Canadian nurses must take a wider interest in world affairs in general and in world nursing in particular.

As I was writing these lines I remembered a page from the book "Gift From The Sea" by Anne Morrow Lindbergh. She wrote:

We are asked today to feel compas-

sionately for everyone in the world; to digest intellectually all the information spread out in public print: and to implement in action every ethical impulse aroused by our hearts and minds. The inter-relatedness of the world links us constantly with more people than our hearts can hold. Faced with this dilemma, what can we do?

Because we cannot deal with the complexity of the present, we often override it and live in a simplified dream of the future. Because we cannot solve our own problems right here at home we talk about problems out there in the world. Can one make the future a substitute for the present? And what guarantee have we that the future will be any better if we neglect the present? Can one solve world problems when one is unable to solve one's own? Where have we arrived in this process? Have we been successful working at the periphery of the circle and not at the center? If we stop to think about it, are not the real casualties in Modern Life these centers called: the here, the now, the individual and his relationships.

The here, the now and the individual have always been the special concern of the Saint, the artist, the poet and, from time immemorial, the woman. She has never forgotten the uniqueness of the individual, the spontaniety of now, the vividness of here.

When we start at the center of ourselves we discover something worthwhile extending toward the periphery of the circle. We find again some of the joy in the now, some of the peace in the here, some of the love in me for thee.

The author goes on to say "and the waves echo behind me, Patience and Faith. This is only a beginning." It is with these two words — Faith and Beginning — that I will end this address, for it is my belief that as long as we have faith we will always have the spirit for more beginning.

ALICE GIRARD
President
Canadian Nurses' Association

The ICN Committee on revision of Constitution and Bylaws plans to draw up a format to be used by national student nurses' associations in drawing up or revising their constitutions. This will serve as a preparatory step for the national student associations who are seeking membership in the International Student Nurses' Unit.

Some national nurses' associations, in recognition of the responsibilities placed upon more fortunate peoples by World Refugee Year, have contributed substantial sums of money to ICN headquarters for use in relief work. The various branches of the Northern Rhodesia Nurses' Association hope to "adopt" refugee families and take a personal interest in them.

Program plans for the 1961 ICN congress are progressing nicely. His Excellency Lord Dunrossil, Governor General of Australia, will open the congress and the Viscountess Dunrossil has accepted an invitation to be its Patron.

— *ICN News Letter* No. 85

* * *

'Twixt optimist and pessimist
The difference is droll:
The optimist sees the doughnut,
The pessimist, the hole.

— McL. WILSON

U.S. Dept. of Agriculture food scientists advise that squeezing a frozen food package to test its hardness is not a guide to the quality of its contents. In a recent release they say, "A frozen food package feels just as solid after storage at 20° F. as it does after storage at zero, but storage at zero or below is needed to maintain the original quality of the frozen food.

Quality of frozen food exposed to temperatures of 20° to 25° F. declines quickly. The damaging effects of such high temperatures cannot be seen or tasted in the early stages, but during just one day of storage at 20° changes occur that will ultimately affect flavor and appearance. Other changes such as loss of vitamin C also start. Moreover, quality lost cannot be restored by lowering the temperature to zero or less, even though this prevents further damage.

* * *

For true success in life there is nothing more important than defeat. A nurse must have chosen for herself a very poor and pitiable ideal if she finds that she can live up to it constantly for, any one who always lives up to the standard she has set for herself, has chosen an ideal that is hardly worthy of the name.

W. N. MONTEITH in *Life and Work*

HYPOTHERMIA

E. S. RUSSELL, M.D.

Generally speaking, it is rather difficult to find a landowner who has much to say in favor of the groundhog or woodchuck. And yet human beings owe him (and other animals with similar habits) a vote of thanks, for his hibernating habits taught us how to save life through use of hypothermia.

HYPOTHERMIA IS AN explicit word used to designate an exciting newcomer to the field of anesthesia. It is another adjunct in the better preparation of the patient for surgical procedures. Cooling permits attack on previously forbidden sites and more leisurely access to sites formerly operated upon in great haste. These include aortic replacements, intracardiac procedures, and interference with cerebral blood flow. A common example of the latter is the berry aneurysm, cause of subarachnoid hemorrhage.

How does hypothermia change things? Every living tissue and organ requires a continuous supply of oxygen to permit its existence. Bering[1] and his associates in Boston, working on monkeys, showed that the brain requires 2.5 to 4.7 cc. of oxygen per unit. This utilization is reduced to 0.8-1.0 cc. when the brain temperature is reduced to the range of 27-31 degrees centigrade. Thus, the oxygen consumption is one-fourth that of brain tissue at normal temperature. It would follow that not only is the oxygen consumption substantially reduced, but the survival time of the tissue in the absence of continuous supply is increased several fold.

At normal temperature the surgeon may interrupt the blood flow to vital tissues such as brain, liver and kidneys for periods of only 2-4 minutes. The same tissues, when cooled, will resist damage from such supply interruption for 6-10 minutes or more.

How are patients cooled? As in any new technique, there are several methods of achieving the same result and the best way, or ways, has yet to be established. Surface cooling is simple and is in most common use. The unprotected body surface is exposed to ice cubes or water or a mattress through which refrigerants are circulated. This proceeds until the body temperature is suitably reduced. Other methods which are a bit more complicated, but which have certain advantages, include extracorporeal cooling and body cavity cooling. Extracorporeal cooling is the withdrawing of blood from the body, passing it through a suitable refrigerant coil and then re-injecting it into the circulation. Kimoto[2] et al have reported selective brain cooling by irrigation of that organ with cooled blood. With this technique the brain temperature is considerably lower than the general body temperature. This appears to be a method of some promise.

During the cooling process, there are a couple of factors that require some attention. Nearly one hundred years ago, Claude Bernard[3] realized that shivering keeps an animal warm by enormously increasing the metabolism. Since shivering is a normal response to a cold skin, then we can expect the same to occur during the cooling phase. The other factor in addition to shivering, is peripheral vasoconstriction. It directly delays cooling by preventing the blood from circulating through the cold skin and subcutaneous tissues. It is an excellent protective reflex for all excepting those whom we wish to cool.

The anesthetist prevents or controls shivering and vasoconstriction by preoperative medication and anesthetic drugs. When talking about the advantages of reduced metabolism, we must note that drug metabolism is also affected. For this reason, drugs such as thiopentone are used only in small

Dr. Russell is clinical assistant in anesthesiology at Queen's University, Kingston, Ont.

doses or avoided and replaced by those excreted by the lungs.

Since it is almost impossible to start an intravenous infusion in a cooling patient, it is established at the time of anesthetic induction. Other instruments used are the electrocardiograph with scope, the electrical thermometer, and frequently an electroencephalograph.

Once the patient is asleep and in the cooling bath, it is necessary to know the body temperature. This requires careful evaluation since it is not the skin temperature that matters, but rather that of the heart and brain. Electrical thermometers are used to record rectal, skin and esophageal temperatures. From these it is possible to get a picture of the rate of cooling, the body core temperature and the drift that may be expected.

A word about "drift" is indicated. It is found that when a patient is cooled from 37° C. to 32° C. and then removed from the bath, the temperature will continue to fall 2-4° C. Why is this? It happens because the blood continues to be cooled by the cold surface of the body. Invariably, the skin or muscle temperature is several degrees below the esophageal temperature and it takes some time after cooling is discontinued for the two to become equal. This phenomenon is well appreciated and actually utilized in that the patient is removed to the table and the operation started as the patient's temperature continues to fall. The temperature is controlled by the use of heat or cold as indicated. Circulated hot air produced by various types of heat cradle is satisfactory in the rewarming phase.

Hypothermia presents certain hazards to the patient. It is of interest to mention the more common ones. Ventricular fibrillation has received much attention since it is a fatal complication unless successfully treated in a very few minutes. Actually, the value of hypothermia is evident when effectual resuscitation after 10-15 minutes of arrest has no associated cerebral damage. Treatment consists of local heart warming by pouring warm saline directly into the chest, electrical defibrillation and occasionally the use of drugs.

The second complication is skin damage. Frost-bite is a real danger, especially if vasoconstriction is allowed to occur during the cooling phase. Burns may occur due to over-zealous warming methods such as "too hot" hot water bottles.

Indications for hypothermia are both surgical and therapeutic. The principle is always the same — reduction of oxygen requirements permitting a temporary decrease or cessation of blood flow to the brain. Surgical procedures benefitted by this increase in operating time include those performed on heart, great vessels, brain and cerebral vessels.

One must remember that there are many procedures, especially those involving the heart and great vessels, which require more time than can be permitted by hypothermia. It is here that the elaborate heart-lung machines, which permit prolonged circulatory bypass, are of such value.

Gray[4], in 1955, pointed out the value of hypothermia when prolonged hypotension was required. Disease conditions where it is of value include thyrotoxic crisis and hyperthermia due to drugs or disease. Hypothermia may be used after a cardiac arrest during operation as it probably reduces the residual brain damage.

In conclusion, hypothermia is a safe and practical procedure that is of great value in surgery which requires short periods of circulatory interruption or prolonged periods of hypotension. It is an exacting and tedious discipline which, when adhered to carefully, makes possible the restoration to health of many patients previously incurable. The nursing contribution is of special interest and value because you will all see, and many of you will contribute, to the changes and advances that will be made in this new field of medicine.

Bibliography

1. Bering, E. A. Jr., Taren, J. A., McMurray, S. D., and Bernhard, W. F.: *Surg. Gynec. Obstet.* Vol. 102, p. 134, 1956.
2. Kimoto, S., Sugie, S., and Asano, K.: *Surgery*, Vol. 39, p. 592, 1956.
3. Bernard, C.: *Leçons sur la chaleur animale.* Paris: Baillère, 1876.
4. Gray, T. Cecil: *Proceedings of Royal Society of Medicine.* Vol. 48, p. 1083, 1955.

The Era of Open-Heart Surgery

DONALD B. EFFLER, M.D.

The nurse who specializes in the care of patients following heart surgery must use every bit of her knowledge, skill and ingenuity every moment she is on duty.

Hypothermia

ALTHOUGH CERTAIN phases of heart surgery can be traced back to the turn of the century, it is only a few years ago that surgeons began to operate within the human heart under direct vision. The earliest of the so-called "open-heart operations" was performed as the patient's circulation by-passed the heart while the patient was under hypothermia. Utilizing various cooling techniques these operations were performed after the body temperature had been cooled to about 85° F., to permit by-pass of the heart for appreciably longer periods than could be tolerated at normal temperature. In bringing about by-pass of the heart, the venae cavae are occluded to prevent or to divert the systemic venous return to the right side of the heart. In this manner the heart rapidly empties itself of all blood except for the amount that returns through the coronary and bronchial circulation. This, of course, drastically reduces the normal cardiac output and within two or three minutes serious lack of oxygen will become apparent in the central nervous system and other important organs of the body. By cooling the patient the safe period of tissue anoxia may be extended up to eight or nine minutes.

Utilizing hypothermic techniques, surgeons were able under direct vision to close defects in the atrial septum, and to open deformed valves in the pulmonary artery. The disadvantage of this method is obvious. The extremely rigid time limit within which the surgeon must work, forces such an operation to become a hasty affair that is performed under considerable pressure. It takes little imagination to see that the clock on the operating room wall becomes the surgeon's mortal enemy, as it relentlessly ticks off the vital moments within which the operation has to be completed. Yet, limited though the technique of hypothermia is, it played a vital part in the development of our present methods of modern open-heart surgery.

Cross-Circulation Technique

Open-heart surgery, as we view it today, began in 1954 with the cross-circulation techniques developed by Dr. C. Walton Lillehei and his associates at the University of Minnesota. The cross-circulation operation required the patient to have a compatible donor of identical blood type. By an intricate system of arterial and venous cannulations, the circulation of the patient and of the conpatible donor were united, and the healthy heart of the donor supplied the arterial blood flow to the patient while his by-passed heart was opened for repair. This technique enjoyed a limited use. It proved conclusively that operations within the beating heart could be performed almost at the surgeon's leisure, if the remainder of the patient's body received an adequate circulation from a proper source. The disadvantages of the cross-circulation procedures are obvious: the compatible donor assumes a tremendous personal risk and the procedure is practical only in patients who are small.

Pump-Oxygenators

From the lessons learned with cross-circulation techniques came the development of the pump-oxygenator. This obviated the need for the compatible donor. Pump-oxygenators of every description have been developed in laboratories throughout the world. These complex instruments are referred to as "heart-lung machines" or, less properly, "artificial" hearts. In es-

Dr. Effler is in charge of the Department of Thoracic Surgery, the Cleveland Clinic Foundation and The Frank E. Bunts Educational Institute, Cleveland, Ohio.

sence, a pump-oxygenator is a device that will maintain the patient's own circulation during a period of total by-pass of the heart and, at the same time, will properly oxygenate the unsaturated blood that normally would be returned to the patient's heart.

Although there are many different types of pump-oxygenators, each employs one of three basic principles:

a. *Bubblers,* which diffuse oxygen in the form of tiny bubbles directly through the blood within the machine reservoir;

b. *filmers,* which expose the blood to oxygen by the use of screens or metal plates as the blood passes over the metal surface in a thin film created by surface tension;

c. *permeable membranes,* through which oxygen and carbon dioxide diffuse to reach or leave the blood in a manner similar to the normal physiologic process of the human lung.

Each of the three methods has its distinct advantages and disadvantages. Nevertheless, there are excellent oxygenators in use today based on each of the three basic principles listed above. Although open-heart surgery utilizing the pump-oxygenator is at present only four years old, it is remarkable how widespread the clinical use of the ingenious device has become. Curative operations are offered to heart patients in most major communities today. Whereas the ultimate in the pump-oxygenator has not been reached, it is amazing to see the refinements that have already developed as this type of apparatus has become more efficient and safer in each year of its short growth period.

Mere possession of an expensive pump-oxygenator alone by no means completes the picture. In paraphrased words, a slogan such as "Have oxygenator, will operate" is, in itself, meaningless. The surgeon alone cannot utilize the device. It requires the cooperative effort of other specialists. Nowhere in surgery and medicine has the need for well-integrated team play become so apparent. In modern heart surgery utilizing present pump-oxygenator techniques the head surgeon no longer stands out as the key figure in the patient's treatment. Rather, the responsible surgeon is the captain of a diversified team, all highly skilled and dedicated to the program that will best serve the patient's need.

The Team

The modern heart team consists of:

1. A surgical core, usually two thoracic surgeons and two surgical residents,
2. two anesthetists,
3. at least two operating room nurses trained in this type of work,
4. a pump-oxygenator unit comprising two or three technically trained persons who understand the entire workings of the pump-oxygenator, and are well grounded in the physiologic aspects of total body perfusion.
5. In addition to the operating room personnel there are blood bank technicians specially trained to process the vital blood reservoir necessary for such an operation.
6. Last of all is the Constant Care Unit where the patient will spend the most critical time of his life — the postoperative period. It is safe to say that the demands made upon the personnel who are responsible for such a unit have developed the epitome of nursing skill. No group of patients in the history of medicine receive any greater degree of skillful nursing care than is provided the open-heart patients.

Nursing Problems

Let us follow a patient from the operating room to the Constant Care Unit after repair of an intracardiac lesion, to gain some idea of the nursing problems involved. The patient has an indwelling cannula in his femoral vein. Several chest tubes afford water-seal suction drainage. Electrodes applied to each extremity permit continuous recording of the electrocardiogram. A nasal tube provides constant gastric decompression, and a blood pressure cuff is worn continuously for several days after operation. In addition to the multitudinous details of preparation necessary within the unit, the nurses apply orderly system to what appears to be a chaotic phase of the patient's postoperative period.

While this is being done, blood specimens are taken for essential body chemistry determinations. A roentgenogram of the chest is made by portable equipment. Infusions of blood, fluids,

and various drugs are prepared and administered. A seemingly never-ending series of observations are recorded for an up-to-the-minute running record of the patient's progress. The nurses become familiar with the values of basic body chemistry determinations. They learn to know the meaning of various pH determinations of the blood, CO_2 combining powers, and assorted hemoglobin values. They become amateur observers of the monitoring electrocardiogram and frequently can detect premonitory early changes in the patient's electrocardiographic pattern. They check the patient's body temperature, since he is prone to have a rapid fall or rise in temperature, either of which can be detrimental at this stage of recovery. If a fresh tracheotomy tube has been inserted, the added responsibility of continual tracheal care must be shouldered by the nurses.

Perhaps the most significant observation of all is the absence of chairs in the Constant Care Unit — here, this basic unit of furniture is classed under unnecessary impedimenta. This is one place where the on-duty nurse rarely has an opportunity for sitting. Even the recording of vital data is performed at a table that stands by the bedside.

To some, this description will sound like an exaggeration designed to build up the prestige of the highly specialized nurse. Actually it only tells part of the story. It is my firm conviction that this new form of nursing specialty, and the wonderful people who have made it possible, need no form of build-up — only recognition of the service that they are performing in the fascinating field of open-heart surgery.

Neurosurgery and Hypothermia

BARBARA ROWLAND

Modern methods of anesthesiology make it possible for the surgeon to carry out operative procedures in vital areas of the body with greater safety for the patient.

MISS BAXTER was 50 years of age and worked as a stenographer for a law firm. It was at the instigation of a friend that she finally sought medical help. Her employer and some of her friends noticed that she had developed a speech defect characterized by slurring and hesitancy. She also became untidy in appearance and disorganized in her surroundings. She did not display the interest in her work that she had previously and errors in typing went uncorrected. Miss Baxter was aware of her typing mistakes and of her difficulty in dressing but she felt that this was due to a numbness of her left hand. She also felt more tired than usual but she blamed this on personal family problems. She had been admitted to hospital previously for a thyroidectomy and later for swelling of her left foot due to a "blockage of a vein." About a month prior to this admission she had an episode of severe headache in the right temporofrontal region accompanied by vomiting. After a few hours the pain subsided but the vomiting persisted. The headaches recurred periodically but were never as severe nor accompanied by vomiting.

Diagnostic Procedures

A diagnosis of right parietal lobe tumor was made, based on the results of physical examination, history, and various tests. During the neurological examination, Miss Baxter was found to be slightly confused and denied having symptoms that concerned her condition. The muscles of the upper and lower extremities were generally weak. She had left facial weakness and her tongue and lips seemed a bit thick. On smiling, the right corner of her mouth

Miss Rowland prepared this study while she was an intermediate student at Kingston General Hospital.

retracted more than the left. Her tongue was found to deviate slightly to the left. The left pupil seemed slightly smaller than the right. Her left arm was clumsy and movement of the left index finger to her nose was poorly coordinated. A sample of her typing demonstrated clumsiness, lack of coordination and ignorance of her left hand.

Sensation was tested with her eyes closed. Simultaneously touching both left and right hands resulted in the patient replying that the right only was touched. She was unable to distinguish between 8, 4 or 0 traced upon the palm of her left hand. The recognition of form was tested by having her feel objects with basic outlines such as cubes and triangles. *Asteriognosis* (inability to recognize objects or forms by touch) was demonstrated with the left hand. An interesting aspect of this examination was the patient's very firm denial that she was unable to distinguish form. It was later noted that if the nurse bringing her medications approached from the left she would have to cross to the front or right side before Miss Baxter would recognize and take her medications.

The patellar reflex was limited in the left leg but normal in the right. Hair on scalp and eyebrows was rather scanty. Sometimes this is a sign of hypothyroidism but, in this instance, a thyroid function test showed normal thyroid activity. A *pneumoencephalogram* (replacement of the cerebrospinal fluid by oxygen injected into the spinal subarachnoid space for x-ray purposes) showed the gas filling only the cisterna magna, some of the subarachnoid spaces and the fourth ventricle. No oxygen passed into the third or lateral ventricles which indicated an obstruction. An *angiogram* (injection of a radiopaque dye into the carotid artery followed by x-ray visualization of the cerebral arteries and veins) showed evidence of a fairly large tumor in the right parietal lobe causing intracranial pressure. Skull x-rays showed evidence of a tumor in the right parietal lobe. An *electroencephalogram* (a recording of the activity of the brain measured in electric current) showed a marked slow wave abnormality in the right temporoparietal area. These findings were sufficient to confirm the diagnosis of right parietal lobe tumor. Plans were made for its surgical removal.

Patient Preparation

When told of the impending operation, Miss Baxter remained calm and cooperative. She gave no sign of apprehension, appearing, in fact, quite unconcerned. Preparation for surgery included deep breathing and coughing exercises taught by the physiotherapist. Potassium chloride was given three times a day. Potassium is essential to normal electrolyte balance, heart action, and muscular control of the body. Blood was taken for grouping and cross-matching because the operation is a long one. Prior to the angiogram, Miss Baxter had received a general anesthetic and during the procedure she had an episode of laryngeal spasm and became quite cyanotic. Preanesthetic medication this time included phenergen, a potent antihistamine. Skin preparation was done in the operating room. It involved shaving the right side of the patient's head and cutting the remainder of her hair short. The hair which was cut off was saved and returned to her room.

Operative Procedure

The operation summary read:

> Right parietal craniotomy under hypothermia for removal of meningioma, right parietal lobe, complicated by cardiac arrest during operation, requiring thoracotomy and cardiac massage.

Hypothermia is used when it is desirable to have a lessened rate of metabolism thus lowering the need for oxygen to the vital centres. Study of the anatomy of this particular area reveals that it is very vascular. Surgery here is likely to cause an interruption in the circulatory system. For this reason hypothermia was used.

The dangers to consider are that the heart may fibrillate or the patient may go into cardiac arrest. However, because of the lowered metabolic rate in hypothermia there is less danger of brain damage due to lack of oxygen and the surgeon has more time for heart stimulation. Miss Baxter's heart went into fibrillation. Her chest was opened and her heart stimulated to regular activity. The operation resumed without giving the surgeon too great a sense of working against time.

Postoperative Care

When the operation was finished, the head nurse on the ward obtained permission to see the patient. She found that Miss Baxter was still in the operating room. The room was so cold that the nurses wore cardigans under laboratory coats while the patient lay on the operating table with nothing over her excepting a cotton sheet and with ice bags to her groins and axillae. Her respirations were between 7 and 9 per minute. She responded well verbally and asked for a blanket. Her color was good. She moved about well. It is interesting to note that although she talked quite freely and appeared to recognize the nurses, she had no recollection of this phase of her recovery when she was questioned later.

During this period she had esophageal and rectal thermometers in position. These were connected to an electrical device that registered the patient's body temperature. A physiotherapist helped the patient with deep breathing exercises. Her temperature was kept at 34°C. and later 37°C. If it went below these levels ice bags were removed; if it went above icebags were added. Throughout the operation and during her recovery an electric warming blanket was kept in readiness under the patient in case she "drifted" too far below the desired temperature.

Miss Baxter was transferred to her bed but kept in the operating room overnight since the room had to be very cold. The surgeon wished to maintain the slight degree of hypothermia for at least 48 hours. In actual fact this "cooling" treatment continued for several days. In the morning preparations were made on the ward for transferring the patient to her own room.

1. *Cooling the room* This was accomplished quite simply by opening the window and closing the room door since it was cold outside.

2. *Throat suction equipment* A portable electric suction was kept on hand. This equipment was certainly life-saving in this instance.

3. *Emergency tracheotomy set and tray* This is a fairly routine request in our hospital postoperatively, but it is seldom actually used. The easy availability of this set was to prove invaluable to us this time.

4. *Emergency drugs* Levodromoran (1-2 mg.) was to be on hand at all times for the control of shivering and sodium luminal (gr. 2-4) for the control of twitching. The interne or the doctor decided the dosage to be given but it simplified matters to have the medication so easily available. Levodromoran is a potent, morphine-like analgesic and sodium luminal has a selective depressant action on the motor cortex of the brain.

5. *Sphygmomanometer, stethoscope and flashlight* These were used in observing vital signs. This is of major importance in brain surgery where a deviation may be the first indication that a serious change is taking place in the patient's condition.

6. *Special mouth care tray* Special mouth care is important with all seriously ill patients but especially so with patients who have had brain surgery. The patient was unable to clean her teeth, swallowing was difficult, and she took very little or no fluids by mouth.

7. *Intravenous equipment and solutions* Flasks of glucose and water, saline and water, with electrolytes added were available in the room. This avoided the frequent opening of the door and the entry of warm air.

8. *Oxygen tank with B.L.B. mask and nasal catheter* This was not used until it became necessary to give Alevaire inhalations.

Nurses from the ward were assigned to 8-hour special duty with Miss Baxter so that any change in her condition would be noted immediately.

When she returned to the ward, the rectal thermometer, enclosed in a metal container, was still in place. From this the amount of cooling or warming needed to maintain the desired degree of body temperature was determined. The esophageal thermometer had been removed. An underwater drainage system cleared the thoracic cavity of secretions collecting as a result of the incision into the chest to massage the heart. A retention catheter drained the urinary bladder. The patient's only covering was a sheet. Her whole body had a "pink and white complexion." She responded well, appeared alert and was not shivering. Avoidance of shivering was important as this is a warming mechanism of the body.

Immediate nursing care included

turning the patient every hour. The nurses encouraged Miss Baxter to turn herself which she did quite easily. Her blood pressure, pulse, respirations and temperature were noted every quarter hour. She was encouraged to take fluids by mouth. An intravenous was running but the doctor did not want to give too much fluid directly into her circulatory system. Ice bags were applied to the groins and axillae as needed to keep the body temperature close to 37°C. They were carefully wrapped in order to avoid a "burn" and, of course, frostbite.

Deep breathing exercises were done every hour though coughing was avoided. A physiotherapist came to the room periodically to help Miss Baxter with this exercise but it was largely the responsibility of the nurses. No bathing was allowed. The doctor wished to avoid friction to the skin and since the patient was so cool, there was actually little need for bathing. It was necessary to observe movement of her extremities. Miss Baxter responded well to stimulation but her left arm was stiff. As with all major surgery, a careful check of intake and output was kept.

To report immediately *any* change in the patient's condition required constant attention to and good interpretation of signs and symptoms. Charting had to be accurate and verbal reporting at the change of shift had to be thorough. At one or two o'clock in the morning even normal conditions for a postoperative seriously ill patient may tend to appear abnormal. To call someone not in constant attendance upon the patient, to confirm a *slight* change in condition is not too helpful since it is very difficult to judge on the spur of the moment. Therefore the nurse caring for the patient must assume the full responsibility for this.

Chloromycetin was given intramuscularly every six hours in 500 mg. doses and 2,000,000 units of penicillin every three hours. The initial dose of Dilantin was 150 mg. and was to be followed by 100 mg. four times a day. Dilantin is an anticonvulsant drug related chemically to the barbiturates.

During the first to third postoperative days Miss Baxter's eyelids became swollen but her pupils dilated equally and responded normally to light. Blood pressure readings and pulse rates remained fairly constant. Body temperature was maintained at 37°C. She was unable to grip with her left hand and she complained that her left shoulder was stiff but she was able to move her arm. There were occasional jerky movements of the left hand. The left side of her body twitched periodically with the twitching spreading to the face and the left eye. Sodium luminal gr. 4 was given intramuscularly to relieve the twitching but it remained pronounced in the left hand. The patient was alert and responded well. Her speech was slurred but she appeared well oriented to her surroundings although she did not realize that the operation had been done. There was little drainage from the chest catheter.

Postoperative Complications

During the afternoon of her first day on the ward Miss Baxter's respirations became labored. A large amount of mucus collected causing a rattle on expiration. The doctor decided to perform a tracheotomy because of the excess mucus. The patient seemed unaware of the operation though she responded to requests for cooperation. The cannula of the tracheotomy tube was suctioned frequently and a large amount of thick, pale mucus removed. The routine of turning and deep breathing was continued. A turning sheet was placed on the bed to help Miss Baxter when she needed assistance. Sustagen, a therapeutic food providing complete nourishment was given by means of a gastric tube.

By the fourth postoperative day, the twitching became convulsive and was more frequent and prolonged. It started in the left corner of the mouth and radiated to the left eye, down the left side of the face to the left arm and hand. Sodium luminal was given intramuscularly p.r.n. in addition to Dilantin. Respirations were slow and deep with a moderate amount of grayish mucus being suctioned through the tracheotomy tube. Her pupils reacted less to light. The temperature in the room had been controlled by the simple expedient of opening the window and closing the door. Unfortunately the weather became very mild. Fans blowing over ice made it possible to maintain the cold environment. A cut-down was established for intravenous fluids

since Miss Baxter was now taking nothing by mouth and the gastric feeding was unsatisfactory. Daily serum electrolytes and chest x-rays were ordered for three days. The chest drainage was discontinued.

On her fifth postoperative day Miss Baxter responded to painful stimuli and the spoken word but her respirations increased to 25 per minute. Expirations became very forceful and her face was very flushed. The surgeon was called. He suctioned the patient deeply through the tracheotomy tube. Many cast-like collections of mucus were removed. Alevaire inhalations with a mask over the tracheotomy opening were ordered to help loosen the mucus in the respiratory tract. Deep breathing was encouraged. The indwelling rectal thermometer had been removed after 48 hours as it was felt it might damage the rectal mucosa. Temperature by rectum, pulse and respirations, along with the blood pressure, were taken only once every hour. The methods used for "cooling" the patient were gradually discontinued and the room was allowed to warm. It was interesting to note that although Miss Baxter's skin felt really cold to touch, she never complained of feeling cold herself. Because of this "cooling" Miss Baxter did not "run a temperature" and hyperthermia, a complication of brain surgery, was avoided.

By the ninth day a cork was inserted into the tracheotomy tube as tolerated. The head of the bed was elevated 30 degrees for short periods. Respirations were easier and regular. At this time the patient was receiving Sodium Dilantin 100 mg. t.i.d. orally. Her cut-down was discontinued and she progressed from fluid to soft diet. Miss Baxter was talkative and cheerful to the extent of being slightly euphoric. All medications continued with the addition of a sedative, phenobarbital gr. 1½, in the evening. The tracheotomy tube, retention catheter and rectal temperature were discontinued. Deep breathing, coughing and observation of movements continued every hour. Procaine penicillin was given intramuscularly every 12 hours in a 1,000,000 unit dosage and the chloromycetin dosage was changed to 250 mg. q.i.d. Aerosol inhalations continued to be given three times a day with the mask now being placed over the face.

Miss Baxter was permitted to have two visitors for 10 minutes each day. She was allowed to have a daily sponge bath, and eventually a tub bath. With the help of the physiotherapist she progressed from "dangling" her legs to walking. Her walking was very clumsy at first and it required considerable patience to take just a few steps. She seemed to be actually helped by her slight state of euphoria which made her consider all tasks as a bit of a "lark."

Rehabilitation

This was a continuous process starting with deep breathing exercises prior to surgery. As soon as she roused from the anesthetic, Miss Baxter began these exercises. Throughout her entire convalescence she was encouraged to help herself as much as possible. Gradually the head of the bed was raised 30 degrees, and activity progressed to sitting upright with feet dangling. Leg and hand exercises were supervised by the physiotherapist. Hands and fingers regained their strength day by day. Soon she was up in a chair, then walking with assistance. She still had a left-sided weakness with a tendency to lean to that side while walking. Always in the best of spirits, she seemed pleased with her accomplishments and became more relaxed and agile as time went by, often mingling with other patients.

Four weeks from her admission date, Miss Baxter left the hospital. She was to visit the physiotherapist twice weekly. The doctor wished to see her in two weeks. Her discharge medications included phenobarbital and Dilantin which her doctor told her that she should continue to take for some time. In approximately four months she returned to her work on a part-time basis and progressed to a full eight-hour day. She still had some loss of function of the fingers of the left hand but this was overcome as she used her fingers for typing.

The wheel that squeaks the loudest is the one that gets the grease.—JOSH BILLINGS

FIRE AND EXPLOSION in the Operating Room

SISTER MARIE PLACIDE, S.G.O.

The operating room should be one of the safest areas in the hospital but it contains many of the elements that can spell danger and disaster. How are these factors counteracted?

IF THE ACCOUNTS OF accidents on the highway, at work and under other circumstances are shocking to us, then how much greater should be our concern over the impressive number of injuries and the loss of life due to explosions in operating rooms? Patients and personnel have every right to expect the utmost in safety in this hospital area.

The frequency of explosion is at least one in 80,000 anesthetics. In Montreal, the number of accidents per year of this type varies from two to ten. In the United States, within an 11-year period, 1938-49, 69 such accidents were reported — 28 involved fire and 41 were explosive. Ten fires were caused by suction apparatus and seven by the electric cautery. Thirty-two explosions were attributed to static electricity and 69 per cent of these occurred in operating rooms that were not provided with conductive flooring.

It seems unbelievable that the weekly toll of accidents with the attendant investigations, recommendations and warnings have done nothing to decrease the growing number of explosions. Three factors are necessary for explosion: combustible material, a means of igniting it, and oxygen. Unfortunately, the factors are always present in operating rooms. They must be controlled in order to prevent possible accidents. Gas and anesthetic fumes such as cyclopropane, ethylene chloride, ether and even nitrous oxide comprise the combustible material.

To eliminate the danger of explosion we only need to replace these agents by others of a non-explosive nature. This, of course, is not possible at present. As an alternative, we must find the means of using our present agents with a minimum of danger. Since anesthetic and gas fumes are heavier than air, they spread over the floor and accumulate from below upwards. For this reason, to prevent explosions we must avoid sparks at floor level and up to a height of five feet. In arranging for air circulation at floor level, we have to take into account the possibility of accidental leakage from various gas cylinders, defective tubing, and residue in anesthetic machines. All such factors constitute a permanent source of danger.

Accumulation of gas and anesthetic fumes, in conjunction with static electricity, is responsible for the greatest number of accidents and is a constant threat. Static electricity is also involved in almost 100 per cent of fires occurring in the operating room.

We know that there are two types of electricity — the controlled current in daily use and static electricity produced by friction of various substances such as wool, silk, nylon, sharkskin and plastic materials. Static electricity is more marked in a dry atmosphere — that is when the humidity is less than 50 per cent. Woollen bedclothes must not be brought into operating rooms, nor should synthetic materials containing nylon. Cotton only should be permitted.

A product called Negastat that possesses anti-static properties may be used in the last rinse water in laundering. It retains its effectiveness for a comparatively long time.

We must not overlook the question of humidity. It has been established that a high degree of humidity prevents the accumulation of static electricity and thus removes a cause of explosion and fire. However, serious explosions

Sister Marie Placide, is a head nurse in the obstetrical department, Ottawa General Hospital. This paper was presented at Marguerite d'Youville Institute, Montreal.

have been reported in 65 per cent humidity which confirms the existence of other factors as causes of accidents.

Domestic currents of electricity can be controlled while static electricity is a great deal more erratic. It exists everywhere, accumulates in varying quantities on objects, depending upon their degree of isolation or lack of grounding. For example, two objects may carry different charges of static electricity — one having 1000 volts, the other 200 volts. Even without physical contact and at varied distances, the electricity charges tend to come into equilibrium suddenly, producing a spark which is sufficient to induce an explosion if combustible elements and oxygen are present.

Three effective means of preventing sparks are:

1. Avoidance of the use of materials likely to induce development of static electricity.
2. Avoidance of friction.
3. Establishment of contact between objects using a common conductor that prevents formation of different electric charges and eliminates danger of sparks.

This contact can be achieved through the use of small chains or wires that come in contact with the floor.

Conductive flooring is able to eliminate static electricity as quickly as it builds up. This quality is dependent upon the resistance of the flooring, its construction and its composition. Some authorities maintain that good flooring of this type eliminates the necessity for grounding. The floor surface must be non-absorbent, without cracks, fire- and water-proof.

To make cleaning easier as well as to reduce danger of explosion, the flooring must be laid without interstices, no matter how small they may be. It should be of wear-resistant composition. Terrazzo sealed with metal strips is quite in order. Progress in the development of flooring materials is constant and the experts who direct the construction of operating rooms must be alert to the use of materials most likely to eliminate all danger of accident.

How should an operating room floor be maintained? A gentle detergent should be used. Oil and grease must be avoided. It is advisable to add calcium chloride to the mopping solution, eight ounces per gallon. This solution increases floor conductivity, Mopping should either be done in the evening or in the morning before the day's work starts. Waxing must be omitted unless a special wax with conductive properties is used.

To ensure that persons moving about the operating room are free from electrical charges, clothing likely to generate static electricity must not be worn and there must be adequate provision for grounding. If not, contacts between two individuals carrying electrical charges or between an individual and an object may produce a strong enough spark to cause explosion or fire.

Preventive Measures

One of the most effective and economical safety measures for operating room personnel is the wearing of conductive shoes. They can be bought from suppliers of surgical equipment and are provided with different conductive factors. They lose their conductivity as soon as a layer of wax covers the sole so that the latter must be cleansed daily with a good detergent.

Shoes can be made conductive by attaching a band of conductive rubber underneath the heel and fastening the ends to the inner surface of the shoe. The foot rests on the ends of the band. This method is simple, easy and sure. Shoes with nails are dangerous since the nails may produce sparking sufficient to cause an explosion if they come into sharp contact with the terrazzo flooring or a piece of metal.

Personnel who visit the operating room only occasionally such as consulting doctors, x-ray technicians and others, must be checked in some way to determine if they are conductors or carrying an electrical charge. A *conductometer* is very useful for periodic floor checks and may be used for other objects as well.

Another source of ignition is the current used for lights and other equipment. Since inflammable fumes tend to collect from floor level upwards, sparks must be avoided up to the five-foot level. Switches and outlet plugs must be placed at or above this height. All electrical equipment such x-ray machines, cauteries etc. should be in good working order and their setting ap-

proved by the anesthetist. The latter must modify his techniques, if advisable, and evaluate the risks of explosion according to the equipment in use.

Other sources of danger are matches, automatic lighters, alcohol lamps, cigarettes and other objects whose use in the vicinity of the operating room should be forbidden.

Oxygen

The final part of our discussion must be centered around the use of oxygen. In the absence of oxygen, fire and explosion are not possible. The normal oxygen content of the air is 20 per cent — an adequate amount to support combustion and explosion. As soon as the oxygen content increases, so does the risk of accident.

Greasy or oily materials and inflammable liquids must not come in contact with oxygen cylinders, valves or regulating equipment. A special lubricant should be used when one is required.

Summary

The following measures are important in prevention of fire and explosion in the operating room.

1. Anesthetic machines should not be covered with drapes. Shifting the drape can cause static electricity.
2. Ether and alcohol should not be used in skin preparation. Not only can fire result from this but the patient's skin may be irritated.
3. Wool, silk, nylon, sharkskin, nonconductive rubber and plastic should not be used in the area where anesthetic preparations are in use.
4. When inflammable substances must be used, they should be kept well away from the anesthetist and his equipment.
5. Anesthetic machines should be moved cautiously.
6. Drapes, rubber attachments and tubing should be attached and removed with great care. Improper handling may cause static electricity.
7. All personnel should wear conductive heels on their shoes.
8. Conductive flooring should be laid in operating room suites whenever possible.
9. When flooring is non-conductive, objects should be grounded.
10. The use of oils, greases or inflammable liquids around oxygen equipment must be prohibited.
11. When adjusting the oxygen regulator, open or close it slowly in order to prevent dust particles getting into it. Stand to one side when opening the valve and see to it that other personnel do the same.
12. Do not use oxygen regulators for any other purpose.
13. Open cylinder valves fully when they are in use and close tightly afterwards.

References

1. Barrett, Richard, H.M.D..: "Explosion Hazards in the Operating Room." reprinted from *Hospital Topics*, October, 1955.
2. "Recommended Safe Practice of the National Board of Fire Underwriters for Hospital Operating Room," National Fire Protection Association, Bulletin 56, June 1954.
3. Peyssand, L. "Du bloc opératoire à la sortie du malade," *Techniques Hospitalières Medico-sociales et Sanitaires*, No. 166, July 1959.

Do you remember that Christ holds up the wild flower as our example in dress? Why? He says God clothes the field flowers. How does He clothe them? First, their clothes are are exactly suitable for the kind of places they are in and the kind of work they have to do. So should ours be. Second, field flowers are never double; double flowers change their useful stamens for showy petals and so serve no ends. These double flowers are like the useless appendages now worn on the dress and very much in the way. Wild flowers have purpose in all their beauty. So ought dress to have nothing purposeless about it. Third, the colors of the wild flower are perfect in harmony and there are not too many of them. Fourth, there is not a speck on the freshness with which flowers come out of the dirty earth. Even when our clothes are getting rather old we may imitate the flower: for we may make them as fresh as a daisy.

FLORENCE NIGHTINGALE, 1878

* * *

A healthy disagreement is often one of the best tonics.

Evaluation of Experience in the Operating Room

AMY E. GRIFFIN, M.S.

Is operating room experience necessary in the basic curriculum for student nurses or could it be eliminated without loss to the learner?

Introduction

CLINICAL EXPERIENCE in the operating room for students in a basic nursing program is as strongly upheld by some as it is denounced by others. The former claim that the values accruing to the student through this experience are invaluable and irreplaceable. The latter believe that the experience should be limited or eliminated on the undergraduate level as the number of professional nurses utilized in the operating room is being steadily decreased by the increasing utilization of the operating room technician, a classification of auxiliary personnel trained primarily on-the-job. That there is a legitimate role for the practical nurse or technician in the operating room has been demonstrated by experience. The rationale underlying the use of such auxiliary personnel, the scope of their activities, and the consequent changing role of the graduate nurse in the operating room has been discussed on the various occasions.

A review of the literature regarding the inclusion of a period of clinical experience in the operating room as part of the basic nursing curriculum, would seem to indicate that:

1. There are strongly held opinions regarding the value of such experience but relatively little research or study has been done in this area to substantiate or repudiate these views.
2. While some nurse educators have deemed it wise to eliminate operating room experience from the basic nursing curriculum, none has outlined as yet either the areas in the curriculum where the values known to accrue from it may be developed or the reasons why the experience in itself is undesirable.
3. The limited number of reported questionnaires submitted to students and graduates in the few studies that have been done indicate that the experience is considered to be valuable and enjoyable but that certain modifications of the programs would increase their value.
4. Considerable thought has been given to the ways in which operating room experience can be made more meaningful. Certain specific recommendations have been made in regard to the planning and executing of this experience.

Purpose of the Study

This pilot project in action research was an attempt to determine the behavioral changes resulting from a four-week period of clinical experience in the operating room in a specific collegiate program. Answers to the following questions were sought:

1. What is the nature of and how adequate are the learning experiences provided in the operating room?
2. Are the behavioral changes that this experience promotes in harmony with the overall objectives of the basic program and the specific objectives of operating room experience?
3. Do the methods of evaluation give adequate evidence of desirable behavioral changes?

Description of the Sample

This study was limited to a total of 16 students who were divided into four groups of four students each. This represented the total enrolment of a particular class. Each group had four weeks of experience in the operating room. A total of 80-100 hours was spent in this area by each student.

Methodology

1. A review of the literature pub-

This is a condensation of a study done by Miss Griffin as a partial requirement for her Master's degree in nursing from Wayne University in Detroit. During the past months she has been engaged in studies for her doctorate.

lished in nursing and related periodicals 1945-58.

2. A review of the over-all objectives of the curriculum and the specific objectives of operating room experience.

3. A review of the learning experiences provided in the operating room.

4. An analysis of the following evaluation measures to determine the nature of the behavioral changes they revealed and the extent to which they gave adequate evidence of desirability:

a. Student evaluation of experience by questionnaire and diary

b. student self-evaluation

c. instructor's progress reports for participating students

d. written examination

e. joint conference by hospital-college personnel.

Findings

The learning experiences provided were varied. They included:

Thorough orientation to the unit and to the central supply room where supplies for the operating room were prepared; demonstration and practice of specific procedures; guided reading and written assignments; surgical films; discussion periods for the sharing of experiences; oral presentation of individual study projects; attendance at special clinics (for example, cardiac catheterization) and conferences (for example, conferences for the surgical and anesthesiology staffs); observation of a variety of surgical procedures and of the patient in the postanesthetic recovery room; carefully selected and controlled participation as a member of the surgical team in the capacity of both "scrub" and "utility" nurse.

The learning experiences were placed in the curriculum at a time when the student had had a sufficient background of classroom and clinical experience to benefit from them (that is, subsequent to the initial introduction to nursing arts and general medical-surgical clinical experience). They were provided in a setting that was particularly conducive to learning because of the facilities available and the cooperation of the hospital personnel which made possible a flexible program capable of meeting the individual student's needs. In the instructor's opinion, the learning experiences were most effective in promoting the development of a degree of skill in functioning in the operating room and in stimulating assumption of responsibility for personal and professional growth by the students. They were least effective in helping students to gain a greater appreciation of the part that surgery plays in the plan of treatment for the patient, the provisions made for his welfare during surgery and the specific contributions made by the various members of the surgical team. This opinion was somewhat at variance with the one held by the students. Their consensus was that the experiences provided were, for the most part, adequate in assisting them toward the achievement of all of the objectives. While a longer period would have permitted the refinement of skill in functioning in the operating room this was not the primary aim of the experience in this particular program.

The majority of the students felt that actual participation as a member of the surgical team and the demonstration and practice periods were the most effective means of learning. All students expressed feelings of fear, anxiety and apprehension at the start of their experience. All excepting two gained a reasonable degree of self-confidence and satisfaction before the experience terminated. A majority of the students (10 out of 16) believed that it made possible the development of a degree of skill whereby they could return to the operating room as graduate nurses capable of applying the principles learned and able to proceed to the development of increased efficiency.

The most significant comments made by the supervisor and instructor in the cooperating agency at the joint evaluation conference were related to the students' apparent lack of fear, their development of self-confidence very early in the experience and their rather rapid adaptation to the situation. It was felt by the instructor responsible for the supervision of the students during this period that these factors might be attributed to the degree of responsibility that the students were encouraged to assume for their own learning; to the number of students supervised by one instructor; to the cooperation of

other personnel in making possible learning experiences that were meaningful to the individual student; and to the fact that the instructor, through her association with the students in previous clinical experiences, had some insight into their individual strengths and weaknesses and could therefore assess, with greater facility, their individual needs and capacities. The students also had the advantage of knowing how to work with this instructor most effectively and what they could expect, to a certain extent, in assistance and support from her.

The behavioral changes promoted by this experience appeared to be in harmony with the over-all objectives for the basic curriculum and the specific objectives for operating room experience.

Objectives of O.R. Experience

Objective I *To develop a greater appreciation of the part surgery plays in the plan of treatment for the patient and what this phase of treatment means to the patient.*

Related behavior:

1. Increased knowledge of a variety of surgical procedures
2. increased understanding of the relationship between specific surgical procedures and related pre- and postoperative nursing care including teaching
3. increased understanding of the relationship between the patient's history and symptoms and the choice and purpose of the particular surgical procedure elected
4. increased understanding of the emotional implications of this phase of treatment for the patient and his family
5. increased knowledge of the various anesthetic agents and their implication for nursing care in the postanesthetic recovery period.

Objective II *To acquire increased knowledge of the provisions made for the well-being of the patient during surgery and the immediate postoperative period.*

Related behavior:

1. Increased knowledge and understanding of the significance of the following: The physical set-up of the operating room and related units; housekeeping in the operating room; preparation and storage of supplies; positioning of the patient; safety precautions to prevent fire and explosion; safety precautions to prevent operative complications, e.g. hemorrhage, ruptured viscera, undue tissue trauma, burning, interference with nerve or blood supply, infection; precautions taken in the wise selection and use of anesthetic agents.
2. Increased understanding of the principles of surgical and medical asepsis as related to the welfare of the patient in surgery.
3. Increased knowledge of the precautions taken in the immediate postanesthesia period to safeguard the patient's welfare.

Objective III (A) *To develop an appreciation of the part played by each member of the surgical team in the total team contribution toward the patient's welfare.*

Related behavior:

1. Knowledge of the particular roles played by the various members of the surgical team and some comprehension of the knowledge and skills required to make each role effective.
2. Understanding of the interdependence of the roles of the various team members, the essential need for coordination of their activities and the kind of interpersonal relationships necessary to achieve such coordination.

Objective III (B) *To develop a degree of skill in contributing as a student nurse to the team's functioning for the welfare of the patient.*

Related behavior:

1. Ability to function as first or only scrub nurse in less complicated surgical procedures and as second scrub nurse in more complicated surgical procedures.
2. Ability to function as first or only utility nurse in less complicated surgical procedures and as second utility nurse in more complicated surgical procedures.
3. Ability to apply the principles of surgical and medical asepsis to avoid the introduction or transmission of infection in this situation.
4. Ability to assist with the preparation for surgery and the cleaning up and reassembling of the equipment in the operating rooms.
5. Ability to function cooperatively with other personnel in the surgical team through the establishment of good working relationships and the acceptance of responsibility for one's own contribution.

Objective IV *To further develop the ability to assume responsibility for*

personal and professional growth.
Related behavior:

1. A greater degree of development of the following personal attributes:
initiative to learn through self-direction
ability to function cooperatively with other personnel
self-confidence
acceptance of individual responsibility
ability to function in new situations
ability to cope with situations of "tension" and "pressure"
ability to make quick and sound judgment
ability to seek help judiciously and to use suggestions appropriately
control of emotional reactions
ability to derive satisfaction from participation in a clinical situation.

2. A greater degree of development of the following skills:
communication
observation
organization
use of available resources for learning
selection of meaningful learning experiences
identification of individual difficulties
finding satisfactory means of overcoming difficulties
problem-solving in order to meet the needs of a situation
application of knowledge and skills gained through previous experiences and synthesis of these with new knowledge and skills
critical thinking in the understanding of surgery performed and pathology discovered
control of bodily movements necessary for good manual dexterity
self-evaluation of performance with increased insight into personal strengths and weaknesses.

The methods of evaluation revealed definite opinions on the part of the instructor and students regarding the desirable behavioral changes that they believed the experience promoted. It was felt by the instructor, however, that these opinions were, in some respects, markedly subjective; that insufficient and inadequate criteria were used as the basis for evaluation; that insufficient evidence was produced by the instructor and the students, in some instances, to validate their statements. At the same time, it was recognized that where behavioral changes include the development of attitudes, understandings, appreciations and personal and professional growth in addition to the acquisition of specific knowledge and skills, no evaluation of achievement can be entirely objective either on the part of the observer (the instructor) or the participant (the student).

Conclusions and Recommendations

This four-week clinical experience was found to be worthwhile to the students from the standpoint of satisfactions derived and behavioral changes effected.

The learning experiences provided were varied and required individual and group effort on the part of the students. They were in keeping with the kinds of experiences provided in the other clinical areas in the curriculum.

The behavioral changes thought to be developed through this experience were in harmony with the overall objectives of the basic curriculum and the specific objectives of the operating room.

The limitations of the study were most marked in relation to the size of the group studied and the element of subjectivity in the evaluation measures used.

Subsequent to this study a course outline was prepared. It was used as part of the orientation for the operating room experience. It included an overview of the course; an outline of the specific objectives with related anticipated behavior; detailed instructions regarding projects to be undertaken during the experience, criteria to be used for self-evaluation.

A handbook of information related to specific procedures used in the particular operating room where the experience was obtained, was prepared to assist the student in adapting more quickly and to facilitate instruction in the time available.

It is suggested that another assessment similar to this study might be conducted on a more extensive basis with improved measures of evaluation and analysis. The behavioral changes that such a study might demonstrate could be evaluated by nurse educators who are contemplating either a modification or elimination of operating room clinical experience for students in the

basic nursing program. Such an evaluation might lead to the determination of whether any of the behavioral changes are unique to this area, whether they might be effected in other areas of the curriculum as effectively or whether it is preferable to retain this particular experience in order to continue to develop specific behavioral changes through it.

The Student Nurse and the Patient in the O.R.

NANCY BURWASH

The student nurse, as a member of the operating room team, has specific responsibilities to the patient.

ALL MEMBERS OF AN operating room group must work together so that the corps of workers may function not as individuals but as one unit having one common interest — the welfare of the patient. The main objective of the nurse on the team is to ensure maximum nursing care for the patient.

In order to give this type of care the nurse must be able to establish a good relationship with the patient. She should be ready to care for him as soon as he arrives in the operating room. She should accept the patient as an individual with fears and anxieties that are often exaggerated by illness. If he is awake the nurse should greet him courteously by his name. She should try and gain his confidence by short, precise explanations. Her warmth and acceptance of the patient's personal fears and physical needs, will help to allay anxiety.

The nurse should check the identity of the patient and the name of his surgeon. She should have the patient indicate where the surgery is to be performed, if one side is involved, and then make sure it coincides with the clinical diagnosis.

Miss Burwash is a student at the Montreal General Hospital.

After the patient's identity is confirmed the nurse should check his chart for a correctly signed consent form, his recorded temperature and if it is elevated notify the surgeon. She should note the preoperative medication, physical preparation, preoperative urinalysis, religion and history.

If the chart is satisfactory, the patient is moved to the operating table. His head is covered with a cap, his gown loosened, and the knee strap secured. A brief explanation of this procedure is given and then he is moved into the theatre. The nurse should remain with the patient until he is anesthetized — under no circumstances should she leave him alone.

Posturing the patient is also a responsibility of the nurse. She should maintain good body alignment, avoid any accidental injury, minimize discomfort and maintain the dignity of the patient at all times.

The operating room nurse must observe aseptic technique. If there is a break in this technique it should be remedied at once.

For the operating room nurse to fulfil all these responsibilities to the patient, she must have a keen sense of duty, be dependable and above all, be exceedingly conscientious.

The Poultry Products Institute tells us that many consumers still do not realize that although they buy them by the dozen, eggs are actually sold by weight. A dozen grade A large eggs weigh a minimum of 24 ounces (1½ lbs.), grade A medium weigh 21 ounces (1 lb. 5 oz.) and grade A small weigh 18 ounces (1 lb. 2 oz.).

OPERATING ROOM TECHNICIANS

SUMI IWAMOTO

Scrubbing for operations has been regarded as a skilled technical procedure. The trend today is to consider the professional aspect of operating room nursing as the function of the circulating nurse.

THE FIRST CLASS of operating room trainees at the Toronto General Hospital was formed in 1957 to assist the nursing personnel. The objectives of the course are to teach the trainees to scrub for operations and to assist the nurses with other duties in the operating room.

Applicants do not necessarily have to have previous hospital experience. They must be between 18 and 35 years of age, in good health and have at least grade ten education. Many of the present technicians were former ward helpers with excellent recommendations from their supervisors. Applicants are interviewed by the assistant director of nursing service and by the operating room supervisor or instructor. Most of the classes average four trainees in number.

During the three months' course, the students live out and receive a monthly allowance. Their uniforms are laundered free of charge. They work a 40-hour week on day duty. The operating room instructor and head nurses take the responsibility for the teaching program. Each trainee is interviewed and her progress evaluated at the end of the first month. The interim report and the final one are sent to the director of nursing.

Lectures and demonstrations total 55 hours. There is a daily review of theory and individual return demonstrations of procedures. When the technicians are assigned to scrub at the end of two months, they have learned hospital ethics, theoretical principles pertaining to the operating room and possess a knowledge of various basic procedures. They also receive instruction in anatomy to permit intelligent scrubbing. Preparation of operating room supplies is made familiar to them by specified work periods in the Central Supply Service department which takes care of all sterile operating room supplies.

The trainees begin their practical experience by setting up the instrument tables. Later they scrub for minor operations and finally for major ones. They are given oral, written and demonstration tests at the conclusion of their course. The pass mark is 60 per cent.

Applicants are told during the initial interview that their training is to adapt them to the operating room and that they will be appointed to the staff when they successfully pass the final tests. Three weeks' annual vacation and a salary schedule are provided in the personnel policies.

The operating room technicians do not administer drugs or take the responsibility for sponge counts. They are never left in charge of an operating room. Skillful and experienced as they may become, they do not assume any responsibility for teaching student nurses. Their goal is to become capable of scrubbing for any type of operation.

As trainees, they are usually very enthusiastic and eager to learn. They have proven to be excellent scrub personnel; have fitted smoothly into the pattern of operating room teamwork on all tours of duty and have been well received by both surgical and nursing staff. Another rewarding aspect of the use of operating room technicians has been their stability as staff members.

Miss Iwamoto is a member of the operating room staff, Toronto General Hospital.

It is understood that one or two enlightened cereal manufacturers will in future pack the free gifts in the packet, with a coupon to be sent in by customers who want the cereal.

— *Punch*

Clinical Landmarks in Alcohol Addiction

R. G. BELL, M.D.

The development of alcohol addiction is such a subtle process that the afflicted individual may not be fully aware of what is happening until too late.

THE WORD "ADDICTION" has come to mean many different things to many different people. Those engaged in the clinical management of addiction can agree on at least one point. It is a complex human disability that cannot be described easily in a few words.

Usually, a physician has clinical "landmarks" which assist in his orientation to a particular disease. These enable him to visualize the various aspects of the disease process and permit him to estimate the duration of the illness, the method of treatment, prognosis, and so on.

For the purposes of this discussion, addiction is simply defined as a harmful dependence upon one or more chemicals. The nature of the "harm" produced by addiction will vary with the chemical involved. For example, food and tobacco addiction can produce significant physical changes but few important mental or social changes. Since addictions of this type do not produce a socially undesirable change in behavior, they are not regarded as particularly threatening to the community as a whole. On the other hand, addiction to alcohol, barbiturates and tranquillizers can produce serious changes in all three areas — physical, mental and social. There are many reasons for this, but two stand out. First, these chemicals can so affect the brain as to produce the phenomenon of "drunkenness." Drunken behavior is unacceptable in most communities. Secondly, with addiction to alcohol, "drinking" eventually *replaces* other activities in the home, on the job, in the community, in contrast to addiction to tobacco in which "smoking" is *superimposed upon* these other activities without replacing them.

This discussion supports the thesis that an addiction should be examined from nine different standpoints: the physical, psychological and social situations existing prior to the beginning of a harmful dependence; the physical, mental and social changes arising out of a harmful dependence; and the physical, mental and social situations after the harmful dependence has been discontinued. With this orientation, the accompanying chart should be self-explanatory. An attempt has been made to indicate the physical, mental and social status before, during and after alcohol addiction.

The following features of the chart are considered worthy of special mention:

A. The Physical Sequence

1. *Before*

A certain physical state must be present to permit alcohol addiction to develop. Thus, the person who is incapable of enjoying any welcome effect from alcohol, regardless of dose, will not become addicted to alcohol

2. *During*

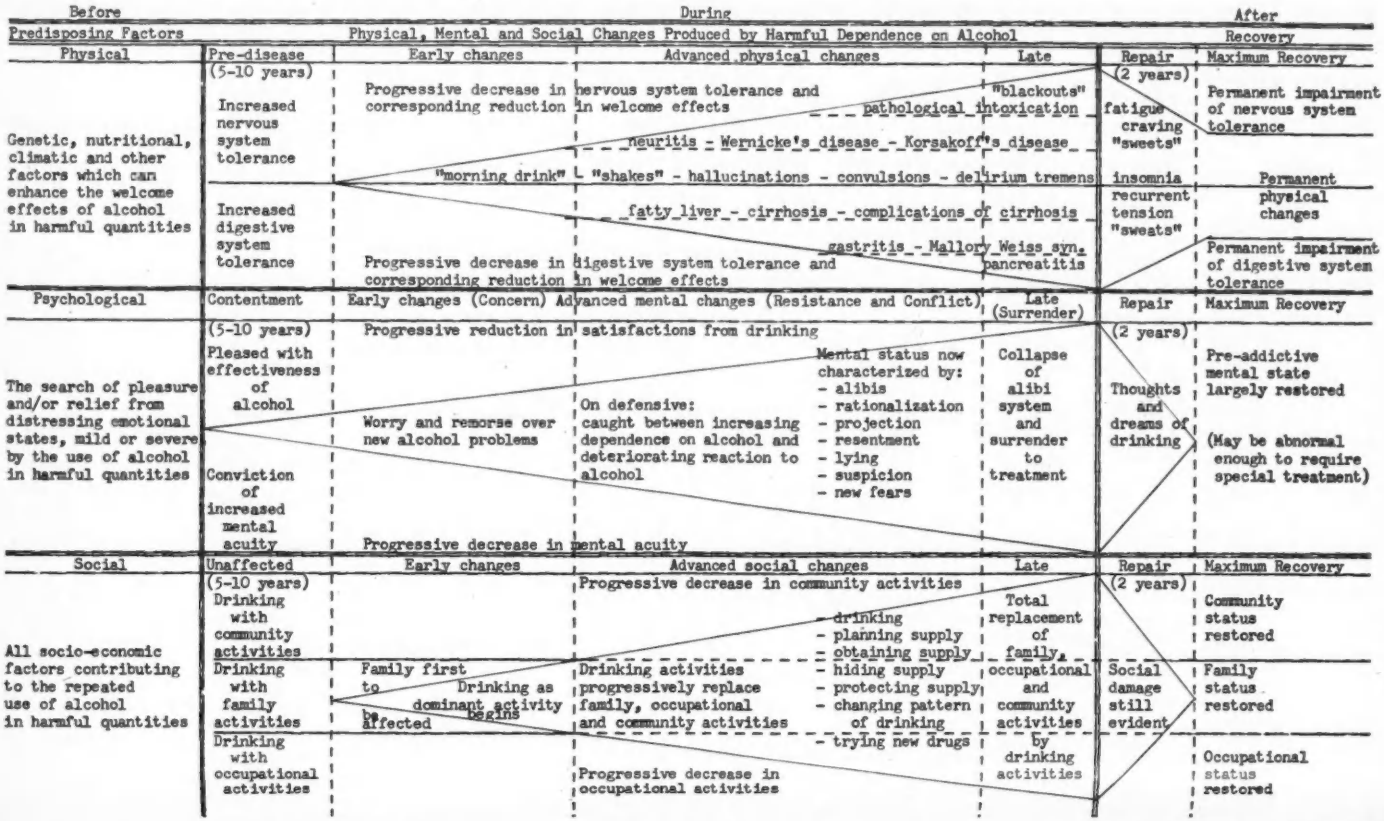
All of the significant physical abnormalities arising out of a harmful dependence upon alcohol occur in either the nervous system or the digestive system. Most of these changes are permanent rather than temporary, for example, those responsible for withdrawal reaction, pathological intoxication, cirrhosis, Wernicke-Korsakoff syndrome. Accordingly, the symptoms of these abnormalities indicate a permanent intolerance for alcohol.

Drinking may be either continuous or sporadic — "chronic or bout." The change from chronic to bout drinking usually represents a break in nervous system or digestive system tolerance — rather than a new psychological phenomenon. In other words, the alcohol addict usually continues to drink regularly as long as his brain or stomach can stand it.

The "blackouts" are deliberately represented as a manifestation of a late rather than an early physical change.

Dr. Bell is the medical director of The Bell Clinic, Willowdale, Ont.

ALCOHOL ADDICTION
(A harmful dependence on alcohol)



Actually, they may occur either early or late in the addiction experience. Too many people automatically associate drunkenness with alcohol addiction. However, when alcohol addiction is recognized at an early age, it is usually because drunkenness and "blackouts" do occur as an early manifestation of a harmful dependence on alcohol. A harmful dependence upon alcohol can be maintained for years without obvious impairment in physical or social status. In such cases, practically the only indication of a significant physical change would be the need for the "morning drink."

3. *After*

The chart indicates that a period of physical repair of approximately two years' duration is consistently indicated, regardless of the combination of physical changes in a particular case. Some of the symptoms experienced during this period are indicated, plus the fact that maximum recovery falls far short of anything that would permit a return to normal tolerance.

B. The Psychological Sequence

1. *Before*

It is important to emphasize that both the search for pleasure and the relief from distressing emotional states can provide the psychological component of the "seed-bed" for alcohol addiction. The distressing emotional states can vary from those considered too mild to be of clinical significance by themselves to the grossly distressing emotional states of severe neurosis or psychosis.

2. *During*

An attempt has been made to indicate that the satisfactory experience of drinking introduces a new element into the thought and emotional life of the patient. The new mental activities concerned with the use of alcohol begin to modify the personality of the drinker, particularly when he begins to be in trouble because of a breakdown in tolerance or in social approval. Eventually, alcohol addicts begin to resemble one another because of the similarity of the thought patterns that accompany later stages of alcohol addiction. This means that the pre-addictive mental state becomes "blurred" and finally "covered over" by the thinking arising out of the addiction.

On the chart, the alcohol addict eventually achieves a "phase of surrender" in which there is a collapse of his alibi system and a willingness to accept help. Prior to this development, he goes through a long period during which he attempts to hold on to his addiction with one hand and his family, occupational and community position with the other.

I am personally convinced that only a small minority of the alcohol addict population resolve this conflict in the manner indicated on the chart. I am also convinced that the great majority of alcohol addicts either die prematurely by suicide or other causes while the conflict is still being actively engaged, or that they surrender completely to the addiction like the "skid row" habitué. The tragedy is that most of these people could be successfully treated if they could be freed from the self-perpetuating mental mechanisms of the phase of "resistance and conflict."

3. *After*

The chart indicates that the reappearance of the pre-addictive mental state during recovery may reveal the presence of long-standing psychological problems sufficiently abnormal to require special treatment.

C. The Social Sequence

1. *Before*

Many communities have established drinking patterns involving the repeated use of alcohol in harmful quantities. A harmful dependence upon alcohol can be more readily developed in such a setting.

2. *During*

It is important to emphasize that very frequently a family can be practically destroyed without any apparent change in the community and occupational situation. It is also important to realize that absenteeism, as a result of a harmful dependence on alcohol, is practically never an early indication of alcohol addiction.

3. *After*

The chart indicates complete repair of the social changes in the two-year period. This is the ideal state. It is possible only if the addiction has been interrupted before gross social changes have occurred. Many family and work situations have been so completely broken up as a result of a dependence

upon alcohol as to be irreparable. Thus, in any particular case, there could be a residue of permanent social changes as well as a residue of permanent physical changes.

Conclusion

It is the responsibility of the physician to explain alcohol addiction clearly to those who are dependent upon alcohol. The industrial physician, rather than the foreman or the supervisor, must assume the responsibility for early recognition of alcohol addiction in the industrial setting. If the physician assumes the same attitude towards the investigation and the treatment of the victims of addiction as he does to the victims of infection, the community as a whole will follow his lead toward more effective solutions to these complicated disabilities.

The Nurse and the Alcoholic

Alcoholism is a disease. The alcoholic must first accept the fact that he needs treatment before he can be treated effectively. Those who care for him must understand him and the nature of his disease to be truly helpful.

ALCOHOLISM IS A DISEASE manifested by acute or chronic excessive indulgence in alcoholic beverages. The definition used by Alcoholics Anonymous is "a progressive illness which can never be cured, but which can be arrested." It represents a combination of physical sensitivity to alcohol and a mental obsession to drink. Regardless of consequences this cannot be broken by will power alone. Most definitions do concede that alcoholism is a disease. It differs from other diseases in many ways. This was pointed out in an article in *The Canadian Journal of Public Health,* September 1957:

> In what way is alcoholism different from other illnesses? To begin with, there is no textbook definition of etiology or of treatment; there are no wonder drugs and no sure controls; there is no well-defined pain or diseased area, and the course of the disease shows about as many variations as there are patients. The alcoholic is sick socially, economically, and spiritually, long before there are any chronic physical conditions. Like the diabetic, he is up and around, except in the acute phases, often carrying on successfully at home and in business, but with one significant difference that for many years he refuses to recognize and to admit to ill-health. He must often lose family, friends and job before he accepts the need for treatment. In what other illness are there so many unpredictable relapses? In what other illness must the patient, in order to get well, give up the one anesthetic which can dull the pain of his suffering?

In Ontario, approximately three per cent of the drinking population become alcoholics. In 1956 there were 76,000 alcoholics in Ontario, 182,000 in Canada. The average alcoholic in Ontario, still has his job, home, and family. One in every six Canadian alcoholics is a woman.

A "problem drinker" is one who persists in repeated excessive intake of alcohol, with little regard for the effect on his family, job, finances or physical well-being. When a "problem drinker" loses control of when he drinks, how much he drinks, and how long a drinking episode lasts, he is an alcoholic.

The precise etiology of alcoholism is unknown. Psychological factors play an important part. Subconscious feelings of insecurity, inadequacy, conflict, guilt, and frustrations may contribute to the disease. Social drinkers may become alcoholics, if social drinks increase in number and frequency. In the business

---

This material was prepared by a small group of students during their experience in the medical department in the first year of their program at The Atkinson School of Nursing, Toronto Western Hospital, Toronto, Ontario.

world a drink "to top off a big deal" may become a necessity.

In some instances alcohol serves as a crutch in the relief of tension. One generation ago it was thought that only weak individuals, or those of defective character would become alcoholics. Today it is realized that alcoholism occurs among all types of people — doctors, businessmen and women, clerks, school teachers, actors, lawyers, skilled workmen, laborers, ne'er-do-wells, and criminals. They do not all lack intelligence, character, responsibility or awareness of moral and ethical standards. Alcoholism may result from an unhappy childhood experience, an over-protective mother; be initiated by a thwarted marriage or by innumerable failures. Alcohol is not the basic cause. In summing up, the causes could be related to: certain types of personalities, plus certain situations, plus alcohol in excess.

The Effects of Alcohol

The liver can oxidize about as much alcohol in an hour as is contained in a highball or a pint of beer. Excess alcohol — the second highball or pint of beer consumed in the hour — circulates in the blood stream until the liver is ready to oxidize it. The following table* shows the effects of the excess alcohol in the blood stream:

less than 1 mg. alcohol in blood — person is dry and decent
1 - 2 mg. — delighted and devilish
2 - 3 mg. — delinquent and disgusting
3 - 4 mg. — dizzy and delirious
4 - 5 mg. — dazed and dejected
more than 5 mg. — dead drunk.

Alcohol acts first as a stimulant and later as a depressant. It is a tension-reliever. It helps to obliterate self-consciousness. The person may have a new but false feeling of security. It creates a temporary elimination of family and business worries. It initiates feelings of superiority and grandeur. Uncontrolled drinking may lead to attainment of many friends, but friends of no import. Alcohol arouses false courage, and is a satisfying flight from reality. Later, when the person becomes an alcoholic, alcohol relieves the craving sensation.

On the other hand, alcohol decreases coordination and slows down physical activity, especially in undertakings requiring skill. Memory, learning, thinking, and reasoning are impaired. Judgment is decreased. Attention and concentration are reduced. It may produce temporary depression. With time, real friends are lost. There may be a family crisis. The person may be involved in automobile accidents or thefts. There may be a loss of self-respect, and a disregard for honesty, or a fear of society other than fellow-drinkers. A vicious circle develops — loss of job, high liquor bills and debts produce more worries, which lead to more drinking. The person may even have suicidal ideas. Prolonged use of alcohol leads to the inability to stop drinking — the major symptom of alcoholism.

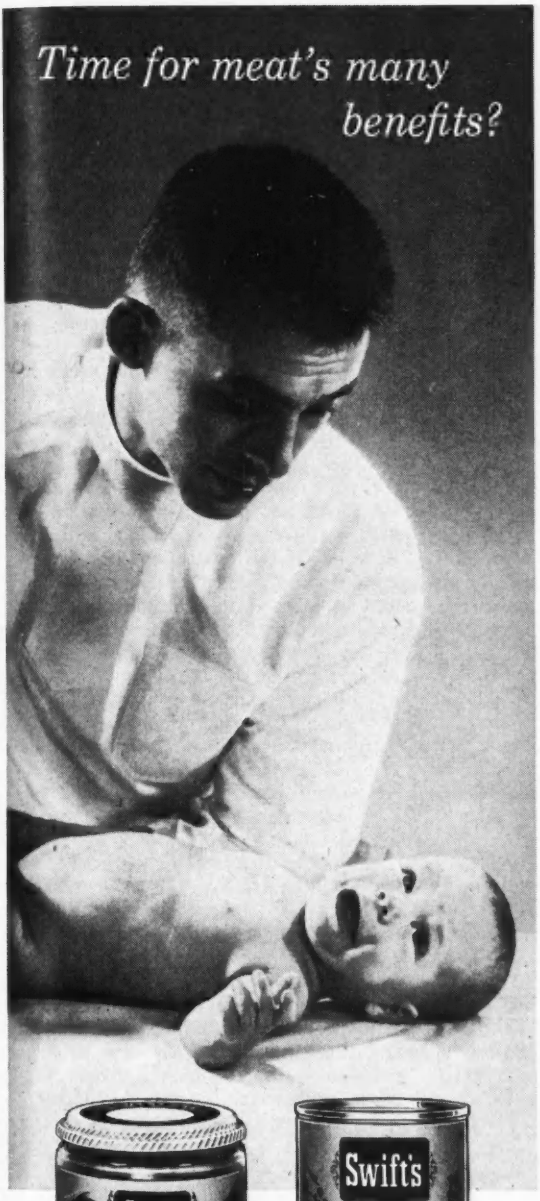
Following a bout of excess alcohol intake, the person may experience acute gastroenteritis. If prolonged he may develop a peripheral neuritis or loss of motor control. With the accompanying poor diet avitaminosis develops and degenerative processes occur in the liver leading to cirrhosis.

Some patients appear in the medical wards of hospitals with delirium tremens. This is a psychic disorder due to the effect of alcohol, and is precipitated by sudden withdrawal, or by stress such as infection. It is manifested by hallucinations, both auditory and visual. The person may see snakes, monsters or fire, and may be talking or shouting incoherently. He may carry out actions for which he is not responsible. Tact and skill are necessary at this time. Argument is useless for he is beyond reason.

Treatment

Stop all alcohol. Sedatives such as Sparine, bromides, or paraldehyde may relieve withdrawal symptoms. Some alcoholics are carried through the acute phase with the aid of insulin. Gastric lavage to dispose of unabsorbed alcohol may be necessary. A bland diet, including large doses of vitamins and fluids, should be started as soon as the person is able to take nourishment. Sleep is important. There must be protection of the patient against suicide or self-harm which may result from

*Muncie, W. Psychobiology and Psychiatry. C. V. Mosby Company, St. Louis: 1948. Page 54.



...then it's time to trust SWIFT ...the meat specialist!

Swift's 105 years of experience as a *specialist* in fine meats benefit your little patients in two important areas.

First, for optimal nutrition, we select *leaner* meat with its higher protein content . . . process carefully to retain vital nutrients.

Secondly, to assure the emotional satisfaction that results from easier feeding times, we strain our meats smoother. And the flavours are so appetizing they aid in establishing sound eating habits early.

Only Swift *specializes* in meats and meat dishes for babies.

The two most trusted words in meat...

100% MEATS EGG YOLKS
MEAT DINNERS

Swift's Premium

confusion and disorientation, or from a desire to escape. In long-term management the drug Antabuse, may be used to produce vomiting if alcohol is consumed.

The nurse frequently comes in contact with the alcoholic in the hospital. Her attitude towards the patient is important. She must look for the real personality of the person she is nursing. She must try to accept and to understand that the untruthfulness, the broken promises, and the need to continue on the path to self-destruction, are just as symptomatic of this condition as the excessive consumption of alcohol. She must try to accept the fact that the alcoholic, although an adult, is a dependent person. Although his attitude, at times, tries the nurse's patience and tolerance, she must seek to cope with this. She must learn to accept the alcoholic's inability to bear responsibility, his tendency to give up easily, his denial of help, his belittling of dependency on others, his jealousy, his impulsiveness, his reaction to authority, his over-talkativeness, his demanding attitude and his need to project blame on others.

Patients with alcoholism need consistent care, but should not be treated like children. The nurse should be firm but flexible. She must help the patient face reality, and help him realize that he must start a new way of life if he wishes to recover.

It is not easy for a person to nurse alcoholics, if pre-formed attitudes conflict with what she is attempting to tolerate and understand. The nurse must think carefully about her feelings and opinions in regard to alcoholism, and read information on the subject to aid in this. She must then feel a sincere desire to help the patient, and make a real attempt to understand his underlying character and his actions. Her care must not only continue during the acute stage, but extend into the period of rehabilitation.

Aid for Alcoholics

Aid comes from many sources: physicians; clergy; public health nurses and social workers; psychiatrists; Alcoholics Anonymous; Alcoholism Research Foundation.

Alcoholics Anonymous is a group of people for whom alcohol has become a major problem and who, by admitting this, have decided to make an honest attempt to build a satisfactory mode of living without alcohol in any form. The only requirement for membership is an honest desire to stop drinking.

The Alcoholism Research Foundation, an independent organization set up by the Ontario Government, conducts scientific research to help find the answers to problems connected with the use of alcohol and alcoholism. It provides pamphlets for the public, alcoholics, and problem drinkers. Clinics for treatment of the alcoholic are set up under its supervision. Treatment and aid are closely related and can only be effectively carried out by co-operation between professional men and women, the above agencies, the public, and the alcoholic himself.

For many years alcoholism was considered a disgrace, a misdemeanor, not an illness. The alcoholic's behavior was thought to be humorous. People were ashamed to seek treatment for their illness and to discuss their condition with others who wished to help. This attitude still persists to a great extent, even though much has been done in the way of public education to break down the barrier to successful control of this disease, and to bring into light the facts about alcoholism.

One way the nurse can contribute to public education is by giving thoughtful interpretation of institutional treatment to alcoholics, their friends, and their families. This will help to establish new attitudes towards this illness, and pave the way for more effective treatment of alcoholism in the future.

Energy and work will often accomplish much more than genius.

* * *

How we steer our course during the day's first hour is important for all of the other hours.

He who will not reason, is a bigot; he who cannot is a fool; and he who dares not is a slave. — Sir William Drummond

* * *

Character is what you are in the dark. — Dwight L. Moody

ONE-STEP PREP

with

FLEET ENEMA
BRAND

single dose
disposable unit

Just *one* second of prep time needed . . . with the modern FLEET ENEMA! Once the full-length protective cover has been removed and the prelubricated *2-inch* rectal tube has been inserted, simple manual pressure does the rest. And *after* the enema — no scrubbing, no sterilization, no setting up for re-use. The complete FLEET ENEMA unit is simply *discarded!*

why more and more hospitals are using the FLEET ENEMA

An efficient, economically-priced, *safe* enema requiring far less time than outmoded procedures, FLEET ENEMA also avoids the ordeal of injecting large quantities of fluid into the bowel.

Left colon catharsis can be achieved in *two to five* minutes without causing pain or spasm,[1] while affording the same cleansing efficacy as the usual enema of one or two pints. Reverse flow and leakage are prevented and a comfortable flow rate assured by the construction of the anatomically correct plastic tube.

Each Single-Dose Disposable Unit contains, in each 100 cc.:

Sodium acid phosphate USP.....16 G.
Sodium phosphate USP..... 6 G.

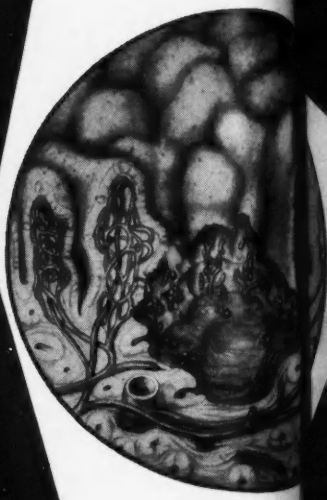
Plastic "squeeze-bottles" of 4½ fluid ounces, with prelubricated tip.

1. Marks, M.M.: Am. J. Digest. Dis. 18:219, 1951

Charles E. Frosst & Co.
MONTREAL CANADA

strengthens
fragile capillaries

in internal bleeding



capillary hemorrhage
in duodenal ulcer

. . . associated with abnormal capillary permeability and fragility in

peptic ulcer

ulcerative colitis

chronic nosebleed

purpura
(nonthrombocytopenic)

hemorrhagic cystitis

ecchymoses

menorrhagia

habitual and threatened abortion

NURSING PROFILES

The appointment of **Marjorie L. Wenger** as editor of the *International Nursing Review* was recently announced by the International Council of Nurses. Prior to taking over her present duties, Miss Wenger had been editor of *Nursing Times* for the past 12 years.

A graduate of Middlesex Hospital, London, England and with her qualifications as a sister tutor, she became principal tutor of her school of nursing in 1941. Later she served as an examiner for the General Nursing Council for England and Wales and took particular interest in professional organization especially in the field of nursing education. As a nurse journalist, and then as editor of *Nursing Times*, she travelled extensively visiting schools of nursing, health centres and occupational health services; attending conferences and congresses in cities as widely separated as Atlantic City and Stockholm, Rio de Janeiro and Rome. She is no stranger to Canada and many of our nurses may recall meeting her at the 50th anniversary convention of the CNA in 1958.

Our warm good wishes and heartiest congratulations are extended to Miss Wenger.

The appointment of **Betty Louise Sellers** as director of nursing service, University Hospital, Saskatoon became effective in mid-June. A graduate of the Regina General Hospital in 1950, Miss Sellers completed requirement for her bachelor of science degree in nursing earlier this year. For the past five years, she has been associated with University Hospital as supervisor of the central supply service, operating room supervisor and more recently as assistant director of nursing service.

Miss Sellers succeeds **Kathleen Ruane** who recently resigned from University Hospital to become the coordinator of an educational program for nurses sponsored by the CNA and CHA.

BETTY LOUISE SELLERS

MARIE E. HUDSON

Marie E. Hudson has been appointed director of nursing of Joseph Brant Memorial Hospital, Burlington, Ont. Miss Hudson, who is a graduate of the General Hospital, Rochester, N.Y. and of Columbia University, New York, was assistant professor of the school of nursing, University of Western Ontario, London immediately prior to this appointment.

She has had considerable experience in the field of nursing administration, having served as director of nursing at Hamilton General Hospital 1953-59 and in the same capacity at Syracuse University Hospital and Rochester General Hospital. She is also a former director of the Hamilton branch of the Victorian Order of Nurses.

The Joseph Brant Memorial Hospital is presently under construction with the of-

ficial opening scheduled for early 1961. The position of director of nursing of it will present fresh and exciting experiences.

E. JEAN MCKAY

The Toronto General Hospital has announced several changes in senior staff positions. **E. Jean McKay** has assumed the duties of assistant director, staff education. This is a newly-created position and Miss McKay will be responsible for organizing and directing the inservice program for professional and auxiliary nursing personnel. She is a T.G.H. graduate with her B.Sc.N. from the University of Western Ontario. Until recently she was assistant director of nursing service at T.G.H.

(C. L. Milne Studios)

M. JEAN DODDS

Margaret Jean Dodds is the new assistant director of nursing service. A 1946 graduate of T.G.H., she took postgraduate study in nursing education at the University of Western Ontario. She has had much experience in supervision and teaching, as operating room supervisor and instructor 1951-58, and for the past two years as nursing service supervisor in the Central and Gerrard Street buildings.

(Victor Aziz)

KATHLEEN PITTS

Kathleen Christine Pitts has been named nursing service supervisor, Central Building, T.G.H. A graduate of the Ontario Hospital, London, she studied nursing administration at the University of Western Ontario. Miss Pitts has been on the staff of the hospital for several years in head nurse and supervisory capacities.

Investigation of wadding samples used in toys, clothing, and padded goods has revealed cases of re-used and insanitary material containing a type of bacterial families that are many and varied, with inherent danger in many groups. Regulations to correct these must be established provincially.

WHY STATISTICS?

MARGARET CAMPBELL, M.P.H.

This is a discussion of the purpose and content of a course in statistics for graduate nurses.

STATISTICS AS A SUBJECT offers a real challenge to some of us, while others are bored or intimidated by the very mention of the word. The latter group likely confuses the facts with the science. Statistics involves two definitions — the numerically stated facts, and the methods of collection, treatment and presentation of these facts. When you consider that the science of statistics had its origin, not in a sterile, thought-provoking atmosphere, but in the gambling halls of Italy, the subject takes on unique color and fascination. It was Galileo who, in the 17th century, prepared his classic treatise on dice to assist his gambling friends in placing their wagers. From this grew the science that enables man to measure, calculate, deduce and ultimately to solve, some of the mysteries of the universe. But no mysteries can be solved without a lively and intelligent interest in the subject.

As thinking people, we deem ourselves capable of separating opinion from fact, of distinguishing associated factors from true causes. Every day, we have countless opportunities to test our ability to do this. We are surrounded with surveys and studies, with collections of quantitative data and interpretations of them. Look at the daily newspaper. In one issue, we may note such items as the state of the federal budget to date this year compared with this date last year; the current number of unemployed and an interpretation of the reasons for its rise or fall; the latest cost of living index and the factors which have made it so; the fraction of adults in a sample who say they will vote for a particular party in a coming election; and data which attempt to relate smoking habits to the incidence of lung cancer, or blood grouping to the incidence of certain pathological conditions. The list is endless and it is taken from only one of the sources of numerical information to which all of us are exposed.

In addition, we encounter data specifically directed to nursing audiences. We are expected to be well-enough informed to react to such data with some degree of critical judgment. Moreover, as a profession, our interests are being increasingly channeled toward research in the nursing field. Therefore, some of our members must be prepared to carry responsibility for such projects with judgment, integrity, and in strict accord with the scientific method. Is it not logical to expect that those nurses who are striving for preparation beyond hospital graduation should be provided with the approach and the tools? This is the group from whom leadership is expected in nursing.

There is no doubt that statistics as a field of endeavor deserves serious study in its own right. The purpose here is to encourage an active interest and alert attitude toward statistics — both the data and the methods of handling them — and to give some basic principles that will help the student to extract truths from veritable forests of facts.

Experience indicates that the majority of nurses who do or should take courses in statistics, are not equipped to pursue a very advanced mathematical approach. Indeed, some have the most acute difficulty with simple fractions, to say nothing of rates and percentages. Even averages and other measures of central tendency have no real meaning. The concept of the laws of probability is most novel and difficult for many students. "Trusting to luck" or accepting someone else's deliberations as to the odds has been their habit, which has permitted them to

Miss Campbell is assistant professor in the school of nursing, University of Alberta, Edmonton.

This paper was presented at the Conference of Learned Societies, University of Saskatchewan, June 1959.

maintain their gullibility with serenity.

We find ourselves faced with the tasks of preparing material that will be comprehensible and useful for students with varying abilities in mathematics, logic and the use of common sense and of presenting it in a concise and interesting way. To accomplish this with any degree of success, the material must be reduced to the simplest terms and closely tied to familiar data. By taking certain raw data from our health bookkeeping — biostatistics — which already has some element of familiarity for the student, and demonstrating certain techniques that render this data suitable for analysis, interpretation and comparison, even rates can take on a fresh, exciting meaning. We indicate the strengths and weaknesses of certain data because some of the most commonly-used rates defy the rules of logic and endure merely for tradition or convenience. This material serves to introduce methods of presenting data and emphasis is on the integrity of the producer of statistics. Certainly, it is commendable to present findings in the most conclusive and convincing manner possible, pointing out and emphasizing the various facts they indicate. But the producer has equal responsibility to confine her conclusions within the limits of her data. She should not cloak, eliminate, neglect to gather nor otherwise twist her information so that the consumer is hoodwinked into accepting an illegitimate conclusion. From the point of view of the consumer, she must have sufficient background to be able to evaluate the offering and decide for herself what to accept and what to reject.

In presenting examples of studies for evaluation, it is unfortunately true that those illustrating *misuse* of statistical methods are more readily found than logical, cautious, well-thought-out studies. However, an excellent and fairly simple example of the latter has to do with the Salk vaccine trials. This study illustrates, in a particularly fine manner, the careful planning down to the most minute detail that was carried out by a group of highly skilled practical people, before a single syringe was lifted. It points out, in a constructive way, that there is more to solving a problem than merely hatching an idea and hoping for the best.

Examples of misuses of statistics surround us. Books have been written on how to lie with statistics. Disraeli must have been exposed to some of this material when he deducted that there are "lies, damned lies, and statistics" in increasing order of magnitude. There is no shortage of illogical, opinion-swaying literature being published in the name of scientific investigation. As a rule, it illustrates the unintentional and thus less vicious type of misuse. Perhaps simple lack of thought in the planning stage of the study or illogical reasoning in analysis of the findings is shown. Nevertheless, this is as misleading as the flagrant, deliberate misuse of statistics with ulterior motive.

In summing up, in the study of statistics emphasis should be placed on reason and common sense rather than mathematical computation. Reason and common sense point out to the student the limit of her knowledge and the areas where more expert help should be secured. It may be in determining size and selection of a sample; the relative weight of a number of factors influencing a result; the significance of an observed difference; the limits of probability regarding the reliability of an interpretation. All may be considerations in studies done by nurses. Students must be better equipped to evaluate studies done by others in order to help to raise the standard of nursing research.

What does the Good Housekeeping Institute do for you — the consumer? It is geared to test any product with scientific precision. For example, a cosmetic product allegedly contains a new "miracle ingredient," but tests show that this substance cannot bring about the dramatic changes claimed in the advertisement. The statements must be revised to conform with the truth or the advertising is rejected by the Institute.

A small oval seal which states "Guaranteed by Good Housekeeping. Replacement or refund of money if not as advertised therein" is your guarantee that the product has passed a series of exacting tests with flying colors.

— *Central Feature News, Inc.*

announcing

TIS-U-SOL™

PHYSIOLOGIC IRRIGATING SOLUTION

new physiologic irrigating solution specifically formulated for use in surgical procedures to maintain cell viability. ******

In vitro studies[1-5] employing established tissue culture techniques demonstrate that TIS-U-SOL, in contrast to so-called "physiologic" solutions, does not cause subtle tissue changes that contribute to complications following surgical intervention.

Because TIS-U-SOL is truly physiologic it supports the metabolism of mammalian cells providing a source of energy and inorganic ions essential for tissue survival.

TIS-U-SOL is used in: wound irrigation[6] / surgical washing[6] / soaking of transplants (autografts and homografts)[7] / irrigation in fenestration procedures[8] / preparation of tissue culture nutrient media[4] /

Also in: Daily Irrigation of Colostomies • Moistening of Sponges and Dressings • Tissue and Bone Bank Media

References: 1. Soltmann, T.: A Manual of Pharmacology, 8th Ed., W. B. Saunders Company, Philadelphia, 1957, p. 1004. 2. Hill, F.: Practical Fluid Therapy in Pediatrics, W. B. Saunders Company, Philadelphia, 1954, p. 104. 3. Harper, J. Y. and Pomerat, C. M.: In Vitro Observations on Behavior of Conjunctival and Corneal Cells in Relation to Electrolytes, American Journal of Ophthalmology 46:269-275, 1958. 4. Pomerat, C. M., and Overman, R. R.: Electrolytes and Plasma Expanders, I. Reaction of Human Cells in Perfusion Chambers With Phase Contrast Time-Lapse Cine Records, Zeitschrift fur Zellforschung, Bd. 463 2-17, 1956. 5. Hild, W.: Ependymal Cells in Tissue Culture, Zeitschrift fur Zellforschung, Bd. 468 259-271, 1957. 6. Rice, C. O.: Personal Communication. 7. DeWeese, M. S., and Hodgson, P. E.: Personal Communication. 8. Shambaugh, G. E. Jr.: Technical Problems in Surgical Treatment of Otosclerosis, J. Internat. Coll. Surgeons 25:772-776 (June) 1956.

WRITE FOR COMPREHENSIVE BROCHURE

BAXTER LABORATORIES of Canada, Ltd.

Alliston, Ontario

Providing for Depth of Learning

RUTH M. MORRISON, M.A.

The group project can be an effective means of teaching and learning.

SOME YEARS AGO A public health nurse friend was coming to spend the weekend with me in my very small apartment. She wrote to say that she had acquired a dog; that she hoped dogs were permitted in the block I lived in; that his name was Caesar Montmorency and would I buy two pounds of hamburger and two beef kidneys since the shops might be closed when she arrived.

Now I, too, had a dog — a smooth-haired fox terrier — and an indulgent landlord who permitted me to keep her provided that she was well behaved, but a second one, and obviously a big one, was quite another matter. So I sought help from a friend who had a large dog of his own and plenty of space. He agreed to provided sleeping accommodation for Caesar Montmorency and my mind was considerably relieved.

On Saturday at 6:30 P.M. a car horn honked and I went out to greet my visitor. She emerged from the car with a suitcase in one hand and a small picnic basket in the other. She handed me the basket saying, "Handle it with care. It contains the sweetest and smallest dog in the world with the largest name."

There is a moral to this little story. The pretentious title of this article may have led you to expect an involved and erudite exposition. On the contrary I simply want to tell you about one teaching method that I have been using for a few years.

May I make two observations?

1. The university does not expect to provide students with all of the answers, but it does expect to increase their ability to ask questions and to learn how to find answers.

2. The practice of public health nursing changes rapidly and the graduates of our schools need to know how to keep up with the changes.

Students tell us, "We want more time to think and reflect." They also tell us they want the benefit of our knowledge. Our curricula are crowded. There is so much to learn and so little time. It is a constant struggle to strike a balance in our programs between "telling" and "guiding." The educational program that is overloaded with facts poured out by teachers is acceptable to none of us. The one in which the faculty turn back all of the responsibility to the students leaves them frustrated and rebellious.

How *do* we "prepare learners to make progressively effective adjustments to a swiftly changing society."[1] How *do* we meet the obligation to provide future practitioners with sufficient factual public health knowledge to begin their careers, and at the same time, equip them with tools of self-direction that will make them capable of continuous growth and professional development so that they can help society to meet its needs. Dr. Mursell has said that

> learning should be organized in terms of understandings which:
>
> 1. seem real, compelling and valuable *to the learners,*
> 2. engage them in active purpose,
> 3. confront them with a significant challenge, and
> 4. lead them to deeper and wider insight, more discriminating attitudes, and more adequate skills.

With all these thoughts in mind I examined the content of the course in principles and practice of public health nursing and selected some topics for special study by groups of students. The purpose was to give the students an opportunity to:

1. Delve more deeply into one phase of public health nursing practice than

---

Miss Morrison, an associate professor in public health nursing at the University of British Columbia and president of the Canadian Conference of University Schools of Nursing, presented this paper at the Conference of Learned Societies held last summer at the University of Saskatchewan.

they otherwise could, through reading, discussion and interviews,

2. participate in a group project similar to those that they will encounter as practitioners,

3. have additional teaching experience.

At the beginning of the term the students are given a list of topics and, whenever possible, they elect the one they want. The groups should be approximately the same size and are arranged by the students themselves.

I meet with each group for the first few times. Some only want my assistance once or twice, to help them to organize. Each group appoints a leader, a recorder, a librarian and a publicity representative. In some groups these persons function throughout the whole project, others alternate the responsibilities. In addition each group appoints two persons to learn to use a projector. When our enrollment was smaller all students had instruction and practice in this. We have to limit it now to selected students and they, quite frequently, teach it to others.

Some of the topics studied have been: Alcoholism and narcotism, home safety, gerontology, prepaid health care plans and handicapping conditions in children. The assignment is given in terms of public health nursing practice. Thus nursing is always stressed and, where applicable, the mental health and rehabilitation aspects are included.

The groups arrange their own times for meetings, methods of research and interviews with resource people. They prepare objectives and design forms for the evaluation of their own learning and of their teaching. They also plan the method of presentation to the entire class. This is an important feature for they know that all of the other students are depending on them for material on which they will be examined, just as they are depending on the other groups. In conference with the instructor they manage to use a suitable variety of teaching methods, and as you would expect, they make some highly original applications of the methods.

Each group meets with me at intervals to check their progress. They are free to proceed at their own pace and in their own way. The only control I insisted upon is that they confer with me before writing, telephoning or visiting people in the community. This is to avoid any one person or agency being troubled too frequently. Sometimes a more suitable person whom they might approach is suggested. Occasionally the first contact, for example with the Chief of Police, or the head of a correctional institution, is made from the office just to keep our "public relations" in order.

A conference with the leaders is held to decide on the dates of the presentations to the class and any other matters that affect the time-table or general program. All of the presentations are given in the last six weeks of the term. Guests may be invited to participate, but not to give a lecture. Since each group has only a two-hour period for the actual presentation they do a great deal of advance publicity through posters, clippings, cartoons, spot announcements in class, scrapbooks, and various other features. Following each oral presentation a written report of the whole project is submitted and is immediately made available in the reading room.

The requirements include keeping a bibliography file from the current magazines up-to-date for each topic. At the end of the term they select the most valuable of these and add references from books, films, pamphlets and reports. These lists are mimeographed and given to every student in the class for future use.

The final group meeting with the instructor is for evaluation purposes. The amount of insight gained not only into the subject but into the reactions and behavior of the group and of each individual member is always amazing.

Some indication of how students who participated in interest groups have been motivated to use the knowledge gained, and to adjust to new situations is evidenced by the following:

One person submitted a paper to the Scientific Papers committee of the Canadian Public Health Association 1958 meeting, on alcoholism and narcotism and its relation to public health nursing practice.

One entire group has continued to hold meetings since 1956 and to work with the Vancouver Safety Council.

Several students have organized discussion groups in their health units with staff, and with lay people.

One group, which made a movie and another which took an excellent series of color slides as part of their project, have a system whereby any of the students in those two classes may use them in their communities.

One graduate was able to overcome strong community objection to fluoridation by using the interest group method. The town now drinks fluoridated water.

Former students also tell us that they feel that they are able to fit into the health team with greater ease; that they appreciate being able to make a special contribution in an area that they have explored fully. They find too that this method stimulates them to seek solutions to problems and not to be satisfied with merely superficial knowledge.

This learning technique appears to embrace several characteristics of sound education. It provides context, focus, and socialization. It encourages organic integration and evaluation. It permits interaction between learners and resource people in the community, and the audience to whom they present their findings. It provides stimulation and results in depth of learning in at least one aspect of public health nursing practice.

In the Good Old Days

(The Canadian Nurse — AUGUST, 1920)

The custom of giving a dose of castor oil the second or third morning of the baby's life is in most cases unnecessary, as the colostrum acts as a laxative and is usually all that is required. Oil should be given only if the meconium is not thoroughly evacuated, or if there is a rise of temperature during the first few days, in which case a very small dose is sufficient.

* * *

Preventive medicine. Sir George Newman, chief medical officer of the English University of Health, says that most diseases are the effect of causes in large and increasing measure controllable. Good cooking was advocated as a pre-requisite of good digestion. Poor nutrition is not a result of the properties of the food, but a lack of knowledge. Four principal diseases — pulmonary tuberculosis, influenza, poliomyelitis and cerebro-spinal fever — were known to be conveyed by inhalation of the causal microbe. A clean mouth, clear breathing passages, abstinence from spitting, sneezing, coughing, shouting or breathing at other people, would go a long way toward prevention. The prevalence of venereal disease is a strain on our civilization. Enlightened public opinion will ensure sanitary reform, therefore education in sanitary methods and objects is imperative. No laws can be successfully applied which have not public opinion behind them.

* * *

The graduate nurse, except in institutional positions where medical and nursing care with the continuance of salary, is given, is faced with total loss of income and the added expenses of illness or accident. Nurses are proverbially extravagant, and in so many cases live from hand to mouth. To them a plan of a cheap form of accident and sickness insurance should appeal. We must in the future do our utmost to influence the young graduates to protect themselves and their income by some form of insurance.

No two things differ more than "hurry" and "dispatch." Hurry is the mark of a weak mind, dispatch of a strong one. A weak man in an office is like a squirrel in a cage — is laboring eternally, but to no purpose; like a turnstile, he is in everybody's way, but stops nobody; he talks a great deal, but says little; looks into everything, but sees into nothing; has a hundred irons in the fire, but few of them are hot; and with the few that are, he burns his fingers.

— COLTON

* * *

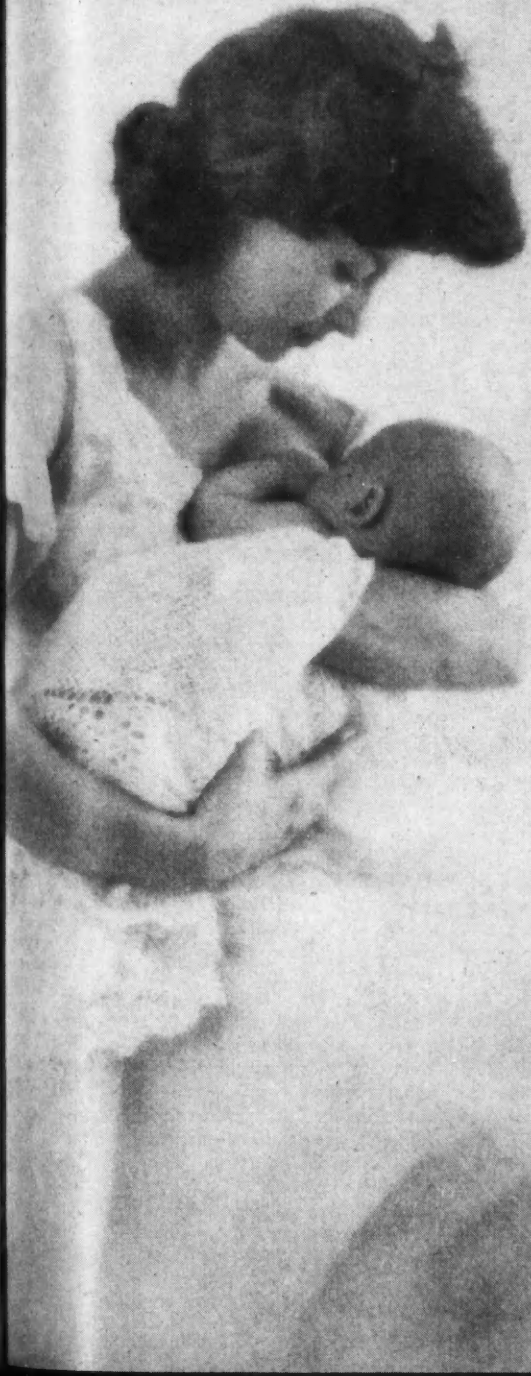
Gratitude is the memory of the heart.

— J. B. MASSIEU

* * *

Every future is possible only because of some past.

AS WITH MOTHER'S MILK . . .



As with mother's milk, S-M-A (Food formula for infants, Wyeth) provides proteins, carbohydrates, vitamins and minerals to meet the known nutritional needs of the human infant. S-M-A compares closely with human milk in percentages of protein, fat, milk sugar and ash

Food formula for infants

Wyeth

Reg. Trade Mark

• WALKERVILLE, ONTARIO

A Different Approach to Psychiatric Social Work

CYRIL GREENLAND

Teamwork in the care of the psychiatric patient ensures more effective treatment.

THIS DEPARTMENT was established in October, 1958. Looking back over the work provides an opportunity to consider our aims and what has been achieved. The function of the Social Work Department is to bring to the psychiatric team information about the social factors that underlie the symptoms presented by the patient on admission to hospital. In this way the social worker helps to identify areas of pressure which may have precipitated the illness. Having defined these areas of conflict, the cooperation of the patient and his family is sought in the process of dealing with them. This function has two interlinked aspects which can be considered under the headings of "inner" and "outer" needs. "Inner" needs are dealt with by helping those patients towards a better understanding of the nature of their problems and on this basis to plan realistically for the future. "Outer" needs are satisfied by rendering appropriate services which, by removing obstacles, provide opportunities for development in the direction of independence. In short, social work is concerned with interpreting the social needs of patients and their families and providing or helping to provide services that encourage healthy impulses towards growth and maturity.

Because we are so few in number and because the demand for service is so great, in practice only a small proportion of patients who need help are actually seen by social workers. We hope in time to provide much more adequate service. When faced with conditions of chronic staff shortage a number of solutions are possible. The available resources can either be concentrated on a limited area or diluted and dissipated over a much wider one. Neither solution is satisfactory. The first falls short because the large majority of patients are deprived of services to which they are entitled, and in any case, how is one to decide who needs help most? The second is equally ineffective because, like a sudden shower at a time of drought, too little rain may be worse than none at all. This method of working is also frustrating because the social worker will find little or no satisfaction in service which is so limited in scope.

In consultation with the medical superintendent, it was decided to divide our resources. My colleague and her assistants, were to carry the main burden of casework services while, I was to be left more or less free to develop and extend the therapeutic resources of the hospital. This was not, however, a one-man-band affair. If these efforts have been successful it is only because of the help and loyal support I received from the doctors, nurses, attendants, administrative staff, and not least, from my own colleagues.

Our first joint venture was with the blind group. The aim here was to use community resources, in this case the Canadian National Institute for the Blind, for the benefit of our 24 blind patients, most of whom had been in hospital for many years. This started as a Thursday afternoon social club. The next phase was a demonstration workshop run by staff generously provided by the C.N.I.B. It was planned that if it proved worthwhile after three months, the workshop was to be taken over by the hospital. Here we were most fortunate in securing the part-time services of a graduate nurse who, before losing her sight, was on the hospital staff. She has been ably assisted by an occupational therapist aide and members of the community service club who between them provide a service which is of great benefit to our

Mr. Greenland is Chief Psychiatric Social Worker at the Ontario Hospital, Whitby, Ont. Thanks are due to Dr. D. O. Lynch, Medical Superintendent, for permission to publish this article.

Reitman's

"WHERE SMART WOMEN SHOP"

'first stop' for your professional wardrobe!

SPOTLIGHTING *La Cross* UNIFORMS

martly and distinctively styled . . .
niforms just the way you like them!

Uniforms illustrated, available in "Sanforized" super-poplin . . . a fabric with delightful 'easy washing and drying manners' . . . an ideal choice for crisp good looks day-long.
A. Sizes 10 to 20,
4.95
B. Sizes 12 to 20,
3.95

DOUBLE SKIRT SHADOW-PROOF SLIPS
Styled in cool white cotton with all-around double skirt, guaranteed shadow-proof.
Sizes 32 to 40 in measured lengths:
Short (to 5' 2") Average (to 5' 4")
Tall (over 5' 5") **2.95**

REITMAN'S "Ballet" White full fashion hose, daytime sheers, measured lengths, sizes 8½ to 11.
.99 pr. 3 prs. **2.85**

REITMAN'S "Van Ultra" plain seamless nylons in White. Daytime sheer sizes 8½ to 11.
.99 pr. 3 prs. **2.85**

ALL ITEMS AT YOUR NEAREST REITMAN STORE,
or write to Reitman's Mail Order Dept.,
3510 St. Lawrence Blvd., Montreal 18, P.Q.

blind and partially-sighted patients.

A similar venture has been the Senior Citizens Club, meeting on Friday afternoon, which provides a very pleasant social occasion for the elderly men and women. This club is supervised by another occupational therapist aide, and staffed by members of the community service club.

One of the difficulties threatening these developments was the shortage of ward staff to supervise and escort patients to these activities. Here, necessity being the mother of invention, a novel and perhaps even a unique solution suggested itself — the community service club. This is a group of women patients united by the single aim of providing service for patients less fortunate than themselves. This club, with its own elected chairman, secretary and leaders, organizes groups to serve the blind, and visits the female pavilions each afternoon. Our experience suggests that opportunities for service of this kind may well be a therapeutic resource of considerable potential value.

In recent years the condition of patients on chronic wards has been the subject of great concern. Evidence now available suggests that the deterioration associated with psychosis is much more related to the environment in which the patient lives than to the illness itself. In short, it is suggested that it is not the illness that is hopeless but rather our attitude towards it. Project Remotivation, a twelve-week "total push" program on the male pavilion, with sociological and psychometric measurement before and afterwards, was a most successful attempt to test out this hypothesis. Particularly rewarding was the response of patients to the appointment of a ward aide, who brought a much appreciated feminine touch. The consequent improvement in the behavior, appearance and habits of these men, most of whom had been in hospital for an average of 16 years, suggests that further consideration could, with profit, be given to the use of female staff on male wards. Members of the Kiwanis Club of Whitby also played a most important part in the Remotivation Project. A similarly valuable development was the industrial workshop which has enabled the patients to sort 6½ tons of auto parts and earn themselves $390.

A further example of the use of community resources has been the classes in English for foreign-speaking patients, sponsored by the provincial Department of Education. A teacher, working under the egis of the O.T. Department has already achieved most encouraging results. This may well prove to be the beginning of a much more comprehensive hospital educational program.

Developments of this kind are in line with the new mental health program. The aim is not only to provide an expanded and more active service, but also to bring mental hospitals closer to the community. This involves not only imaginative changes in policy and organization but also in the training of staff. A recent addition to the syllabus of the school of nursing is a course of 48 lecture-demonstrations on the sociology of social problems. This will be consolidated by a month of practical work in the social work department.

The community is also enthusiastic to be of service to the mentally ill. In this respect there have been a number of exciting developments. Of particular interest has been the recent inauguration of the Oshawa and Ontario County Branch of the Canadian Association of Mental Health. Equally important is the "Orientation Course in Psychiatry," at this hospital, for public health nurses. It is hoped that this will lead to more effective cooperation between the public health departments and Ontario Hospitals, particularly in the fields of prevention, early diagnosis and aftercare.

The past ten years have seen great advances in the treatment of mental illness. Looking forward to the next decade one can already see the outlines of new and possibly very different patterns of psychiatric service. It now seems likely the greatest progress will be made in fields of pharmacotherapy and social psychiatry. The success of both these developments will depend on the closest collaboration between psychiatry, nursing and social work.

Every country has the government it deserves. — DE MAISTRE

MARGUERITE D'YOUVILLE CLUB

ALPHONSINE DION

IN THE FALL OF 1956, UNDER the guidance of the late Sister Levasseur, then director of education, a new club was formed at the Grey Nuns' school of nursing in Regina. Sister Levasseur felt that there was a need to provide recognition for honor students and at the same time a means by which these same people might give scholastic assistance to other students. The Marguerite d'Youville Club, named after the foundress of the Grey Nuns' nursing order in Canada, adopted the motto "Science through Friendship."

A meeting was held and the constitution was drawn up. In order to be eligible for membership, students must first obtain an average of 85 per cent after completion of the six months' preliminary period. They must also have shown excellent decorum in the hospital and the school of nursing. These students are presented with a membership card signed by the director of nurses, at their capping ceremony, signifying their eligibility for membership. Membership in the club is on a voluntary basis. The student signs an agreement to show that she is willing to join the club and to abide by the regulations.

Membership pins are presented by the alumnae association which has assumed financial responsibility for the club. To receive a pin, the student must instruct another student whose name has been submitted to the club by the faculty. A record of subject matter covered is kept and the number of hours of tutoring. The round pins are one-quarter inch in diameter and consist of a centre of gold depicting a lamp, the symbol of nursing, upon an open book, the symbol of knowledge, encircled by a blue border with "Marguerite d'Youville Club" in gold lettering. Pins may be worn on the upper left side of the student uniform.

Membership to the club is forfeited:

1. Voluntarily,
2. By inability to maintain membership standards,
3. By withdrawal from the school of nursing.

Club members must maintain an average of over 80 per cent in all subjects. If a student fails to maintain this average in her junior or intermediate terms, she must forfeit her pin. She may regain it by obtaining an average of 80 per cent in the senior term. In the event that the student does not meet the standard in her third and final year, she may keep her pin if the average of all her marks is above 80 per cent. Recognition is given to these students by having their names put on the Honor Scroll in the classrooms. A full page of the yearbook is set aside for a group picture.

The faculty act as advisers to the club. A chairman and a secretary are appointed from members of the faculty. The duties of the faculty advisory committee include presiding at all joint meetings of the Marguerite d'Youville club and the faculty; keeping a record of the proceedings of meetings and the membership of the club; submitting financial matters to the alumnae association; preparing a report for the alumnae association twice annually which includes the names of new members and current members, the number of students tutored and the number of hours spent doing it.

The executive committee of the club consists of a president, vice-president and secretary elected by the members. Members attend joint meetings of the faculty advisory committee and the Marguerite d'Youville Club which are held at least three times a year at the request of the educational director or the president of the club. The meetings take place prior to the announcement of memberships and the distribution of pins. Extra activities of the club include such things as "nursing study nights," when nursing care studies are presented to the student body. These are chosen from the total number written by the students. Club members also help prepare review classes.

What is the value of such a club? To the non-members it serves as an incentive for more diligent study and intellectual activity. To the members it means that they must be exemplars of the standards of the school of nursing and the hospital. It also means that they may assist in ward supervision of preliminary students upon the recommendation of the faculty and clinical instructors. It gives them an opportunity to give of their knowledge and encourages them to think of postgraduate study.

Sciencia per amicitiam — Science through friendship — and hard work.

Miss Dion, a former member of the Marguerite d'Youville Club of Regina Grey Nuns' Hospital, graduated in 1959. She is presently on the staff of the hospital.

PARENTS AND MENTORS

Schools of nursing are beginning to admit not only prospective students but also their parents — with benefit to both sides.

The day that Betty formally enters the school of nursing, Mother and Dad usually accompany her to the nurses' residence where they may meet her instructors, her director of nursing, her classmates. Then they leave her to the rather mysterious process of becoming a nurse.

In the next three years they will gather scraps of information as Betty writes her weekly letter or comes home on days off and holidays. They will be impressed by her knowledge of cardiac surgery, vaguely worried over what appears to be a crushing schedule of work in the operating room and, sometimes, genuinely distressed when Betty is discouraged and discontented. They would like to help her but they do not know what to do or say since they feel that she is in a world of which they have little or no understanding.

The idea that parents should be brought into the life of the school of nursing is beginning to gain acceptance. In 1957 the Hotel Dieu Hospital, Kingston initiated its Parent Teacher Association. The teaching staff felt that the help of the parents would be invaluable in solving some of the problems that arose in dealing with the students. Last spring, the Montreal General Hospital organized its School of Nursing Associates — a group composed of the parents or guardians of the students. The initial response to the suggestion that such an association might be formed was most enthusiastic. The parents were grateful for an opportunity to learn more about the school and its program.

The executive of the Associates is elected from the ranks of the parents and meetings of the membership take place at its request with an annual meeting definitely scheduled for April of each year. The aim of the Associates is to be as well-informed as possible about the school of nursing, its program and its objectives so that they, in turn, may inform the general public. This could result in a stimulus to recruitment from which the School will benefit. In addition the School will have an opportunity to sample public opinion reliably. A long range objective of the Associates is the provision of bursaries for deserving students as tangible evidence of their appreciation for the training their own daughters are presently receiving.

The concept of the hospital as an integral part of community life is receiving increasing emphasis. It is quite reasonable then to expect that the people within the community should have or be encouraged to take an active interest in those phases of hospital life where they can serve effectively.

In addition to the Associates, the M.G.H. school of nursing has set up a "mentor system" that is unique, according to present knowledge. The members of the student body have come from widely separated areas in Canada and a number of countries beyond our national boundary lines. They also represent varying degrees of maturity and as many differing personalities as there are individuals. The students need help in developing good work relationships and personal relationships. Some require assistance in forming friendships; others need a sympathetic listener and wise counsellor for personal problems. The mentors, who are head nurses, supervisors or administrators, provide the answer. Beginning in September, 1959 each mentor was assigned four girls from the class of students who were just beginning their training. The mentor arranged for interviews with her students during which the members of the little group came to know each other on a more personal basis. During these early months, interviews were frequent but they will diminish in number as the student attains greater seniority. Each mentor is responsible for her particular group of students throughout the entire course of their training. She is the one to whom they will be able to turn for support, encouragement, comradeship, kindliness.

Although still in its infancy, the "mentor system" has proven most gratifying. The mentors enjoy their contacts with the students. This particular class of students has responded by unusually rapid and good adjustment to the life of the school. It is anticipated that a certain percentage of "drop-outs" may be prevented through finding and solving problems in the early stages. The end result is envisioned as a group of nurses who are better developed personally as well as professionally.

The concept of the school of nursing as an educational unit, quite apart from the service needs of the hospital, is an accepted ideal. This has led to a greater appreciation of the needs of the student nurse as an individual and developing personality. The mentor system is a definite step toward meeting normal human needs. J. E. M.

In Memoriam

Madeline (Spencer) Burnham, a graduate of the Victoria Public Hospital, Fredericton, N.B., died on January 19, 1960 in Stoughton, Mass.

* * *

Mary Norine (Mulcahy) Campbell who graduated from St. Michael's Hospital, Toronto in 1937 died on April 25, 1960.

* * *

Barbara Clark, a graduate of the Children's Memorial Hospital, Montreal in 1934, died on May 6, 1960. She had served as a nursing sister during World War II and had been a staff member of Queen Mary Veterans' Hospital, Montreal, up to the time of her final illness.

* * *

Eglantine Clément, the first nurse to graduate from Ste Justine's Hospital, Montreal died in March, 1960. After graduation in 1910, she served with the Victorian Order of Nurses in the city for several years. Later she returned to her hospital to conduct an orientation program for volunteer workers. She was 84 years of age.

* * *

Effie M. Comper who graduated from Riverdale Isolation Hospital, Toronto in 1929, died on May 1, 1960. She had been engaged in institutional nursing during her professional career, having served on the staff of her hospital for 31 years.

* * *

Eva G. (Ham) Hanna, a graduate of the General Hospital, Stratford, Ont. in 1928, died on March 13, 1960.

* * *

Margaret Emerald (O'Connor) Kitchen who graduated from St. Andrew's Hospital, Midland, Ont. in 1936 died on January 3, 1960.

* * *

Teresa Mary (O'Meara) Lane who graduated from the General Hospital, Ottawa in 1932 died early this year. During her professional career she had engaged in private nursing.

* * *

Elizabeth C. (DuVall) Newlands, a graduate from the New York Hospital, New York in 1922 died in Toronto during 1959.

* * *

Grace Agnes (Hall) Noble who graduated from St. Joseph's Hospital, Port Arthur, Ont. in 1913 died on March 21, 1960.

* * *

Evelyn S. Padgham, a graduate of the Ontario Hospital, London in 1930 died on February 3, 1960. She had been engaged in institutional nursing.

* * *

Florence Edna Payne who graduated from Grace Hospital, Toronto in 1918 died on May 14, 1960.

* * *

Marion Viola Phillips, a 1930 graduate of the General Hospital, Hamilton, Ont., died earlier this year. She had been engaged in institutional nursing.

* * *

Zena Pue, a graduate of the General Hospital, Belleville, Ont. in 1919, died in April, 1960. For the past 30 years she had been on the staff of the Deaconess Hospital, Detroit, Michigan.

* * *

Gladys (Barker) Richards who graduated from Grace Hospital, Windsor in 1932 died on February 3, 1960.

* * *

Madeleine M. Smith, a graduate of the General Hospital, Brantford, Ont. in 1927 died on April 14, 1960. She had engaged in private nursing during her professional career.

* * *

Sarah Woodcock, a graduate of St. Joseph's Hospital, London, Ont. in 1920 died recently. She had been engaged in private nursing.

Board Members

BOOKER T. WASHINGTON once said:
"A board is something long and hard and narrow."
Boards are not made of living wood;
No young sprigs on a board are fitting
Sap makes things grow, you know, and could
Disturb a Board's perpetual sitting . . .
Creative youth makes change and motion
And many a Board prefers to sit.
It sits on youth, without a notion
That youth instead should sit on it.

FREDERIC ALMY — "On the Use of Boards"
Survey, Dec. 1/33 — p. 265.

Book Reviews

Sociology and Social Problems in Nursing by Sister Mary Isidore Lennon, R.S.M., R.N., B.S., M.A., M.S.S.W. 491 pages. The C. V. Mosby Company, St. Louis, Mo. 3rd ed. 1959. $5.00.

Reviewed by Miss Jean Grose, Educational Director, Misericordia Hospital, Winnipeg, Man.

The purpose of this edition is to present fundamental principles in sociology and to encourage the student nurse to apply them in the care of all patients.

This text is excellent as a sociology reference. Sister Lennon has clearly shown an appreciation of the changing trends in nursing as an integral part of society, and in society as a whole.

The material is presented in orderly sequence. The interest of the reader is held and the context can be readily understood by student nurses.

I was particularly pleased with the chapter on "Communications in the Hospital." This is an important area of nursing on which more emphasis should be laid. I enjoyed the review questions at the end of each chapter both as an aid in teaching and as an incentive to learning.

The Practical Nurse by Kathryn Osmond Brownell, R.N., B.S. and Vivian M. Culver, R.N., B.Ed., M.Ed. 899 pages. W. B. Saunders Company, West Washington Square, Philadelphia. 5th ed. 1959. Price $6.00.

Reviewed by Mrs. B. Gilmore, Coordinator, Misericordia Hospital, Winnipeg.

This book presents a comprehensive and up-to-date outline of the subject matter in a course for practical nurses. A new and completely rewritten edition, it is well abreast of the latest thinking in nursing practice.

The text is divided into 14 units covering the fundamentals of all aspects of nursing care. The presentation is concise and readily understandable. The summary at the end of each chapter provides an excellent review.

The text is highly recommended as a source of information and review for practical nurse students and graduates and as a guide for instructors. Several sections might well serve as a syllabus for courses for the student professional nurse. This is a valuable and welcome addition to the literature available for both practical or professional nurses.

With Tampax, you can enjoy active fun . . . feel as comfortable and safe as at any other time of the month.

Millions of vital, healthy young women use Tampax by the billions. Like you, they use it—choose it—because it helps them forget about differences in days of the month. Invented by a doctor for the benefit of all women—married or single, active or not. Proved by over 25 years of clinical study.

Tampax internal sanitary protection is made only by Canadian Tampax Corporation Limited, Brampton, Ontario. Samples and literature will be sent upon request.

TAMPAX

SO MUCH A PART OF YOUR ACTIVE LIFE

EMPLOYMENT OPPORTUNITIES

ADVERTISING RATES

Canada & Bermuda — $7.50 for 3 lines or less; $1.50 for each additional line.

U.S.A. & Foreign — $10.00 for 3 lines or less; $3.00 for each additional line.

Rates for display advertisements on request.

All advertisements published in both English and French issues. Closing date for insertion or cancellation orders, SIX WEEKS prior to date of publication.

English issue published the first of each month.

Address correspondence to:
THE CANADIAN NURSE JOURNAL
1522 SHERBROOKE STREET WEST
MONTREAL 25, QUEBEC

ALBERTA

Instructors Classroom & Clinical for May, 1960 or later. Starting salary $320 without degree & $355 with degree. Good personnel policies. Apply to: Director of Nursing Education, St. Michael's School of Nursing, Lethbridge, Alberta.

Registered Nurses or Graduate Nurses for General Duty (2) for 16-bed hospital, centrally located between two very good summer resorts etc. Salary schedule according to suggested A.A.R.N. namely $275 - $300 & adjusted according to experience since graduation. Living in accommodation available at $30 per mo. & Blue Cross on a 50-50 basis. Apply: Mrs. I. Bergquist R.N., Matron, Municipal Hospital # 43, Bentley, Alberta.

Registered Nurses for 44-bed hospital, salary $325 per mo. with $5.00 increments per mo. after each 6-mo. service, board & room $30 per mo., group medical & hospitalization plans available. Apply: Holy Cross Hospital, P.O. Box 339, Spirit River, Alberta.

Registered General Duty Nurses (4) for 32-bed hospital with program of building an addition this spring. Salary $300 - $330; 21-days vacation with pay after 1 year service plus 11 statutory holidays, 1½ days sick leave accumulative. $30 per mo. deduction for room, board & laundry. $10 extra for 11-7 shift. For further information, apply to: Mrs. Pauline Landry, Matron, Municipal Hospital, Fairview, Alberta.

Registered General Duty Nurses (2) immediately for active 30-bed hospital. Salary $270-$295 per mo., 40-hr. wk., 21 days vacation after 1 year, plus all statutory holidays, 1½-days sick leave per mo., room, board & laundry $30 per mo. if desired. For further information apply: Matron, Municipal Hospital, Magrath, Alberta.

Registered General Duty Nurses for busy 45-bed hospital, with program to start building this year, a completely modern 70-bed hospital with 100-bed service facilities. Salary $275-$305, 40-hr. wk., 21 days vacation after 1-year service plus 9 statutory holidays, 1½-days sick leave per mo. accumulative up to 90 days. $35 per mo. deduction for room, board & laundry. For further information, apply to: Matron, Municipal Hospital, Peace River, Alberta.

General Duty Nurses (in early fall) for 52-bed active hospital situated on main highway between Edmonton & Calgary. 5 practicing doctors. Salary range $270 - $310 depending on years of experience, less $35 for full maintenance. 3-wk. vacation plus 10 statutory holidays after 1 year service. Pension plan available. Apply to: Mrs. E. Harvie, Matron, Municipal Hospital, Lacombe, Alberta.

General Duty Nurses starting June 1st. for summer relief & steady employment for 54-bed hospital, 40-hr. wk., gross salary $278.60 per mo. with 3 annual increases less $35 maintenance, 1-mo. vacation after 1-yr. service. Voluntary pension plan & compulsory M.S.I. & Blue Cross Groups in operation. Apply: stating references & experience if any, to: Matron, Municipal Hospital, Vermilion, Alberta.

General Duty Nurses for 34-bed hospital. Salary $270 with 6- $5.00 increments every 6-mo. to maximum of $300, modern residence — $20 per mo., 40-hr. wk., vacation 1-mo. including statutory holidays, M.S.I. & Blue Cross plans in force. C.N.A. pension plan available. Apply: Miss M. M. Sissons, Matron, Municipal Hospital, Vulcan, Alberta.

General Duty Graduate Nurses for active 76-bed hospital, near Calgary & Edmonton, $275 gross salary for Alberta registered, $265 gross salary for non registered in Alberta. Excellent personnel policies & working conditions. Apply to: Matron, Municipal Hospital, Brooks, Alberta.

General Staff Nurses (immediately) for new modern hospital of 243-beds, 37-bassinettes. School of nursing has a present enrollment of 58 students. Temporary residence available in new nurses' home. 40-hr. wk., with liberal personnel policies. Apply to: Director of Nursing, Municipal Hospital, Medicine Hat, Alberta.

Graduate Nurses for General Duty in new 30-bed hospital 90-mi. from Calgary on Trans Canada Highway. 44-hr. wk., generous personnel policies. For particulars apply to: The Matron, Municipal Hospital, Bassano, Alberta.

BRITISH COLUMBIA

Head Nurse for Pediatric Ward General Hospital with school of nursing. Able to assist with student teaching program. Salary based on experience and/or postgraduate preparation. Applications should be addressed to: Director of Nursing, Royal Inland Hospital, Kamloops, British Columbia.

General Duty Nurses for small active hospital. Salary $270 for unregistered, $285 registered with yearly increments. Nurses' home available. For further particulars write, The Administrator, Lady Minto Hospital, Ashcroft, British Columbia

General Duty Nurses for 200-bed General Hospital with School of Nursing. Salary $275-$327. Pre-planned shift rotation, B.C. registration essential. 4-wk. vacation after 1-yr. Apply: Director of Nursing, Royal Inland Hospital, Kamloops, British Columbia.

General Duty Nurses for 110-bed hospital in B.C.'s Northwest. Salary $299 per mo., if experienced; $285 - $342 in 4-yr. Modern residence facilities available. Supervisory positions also available, $330 - $400 per mo. For complete information apply to: The Director of Nursing, General Hospital, Prince Rupert, British Columbia.

General Duty Nurse for well-equipped 80-bed General Hospital. Initial salary $285, maintenance $47.50. 40-hr. 5-day wk., 4-wk. vacation with pay. Apply: Sacred Heart Hospital, Smithers, British Columbia.

General Duty Nurses for 25-bed hospital, 35-mi. Vancouver, on coast. Close to Garibaldi Park Ski-ing lodge. 1-hr. to city, bus & train service. Salary BCRN $285 - $359 (4th. yr.) non-BCRN $270 - $282 (1st. yr.) Excellent personnel policies. Apply: Director of Nursing, General Hospital, Squamish, British Columbia.

General Duty Nurses (2) (immediately). Starting salary $285, personnel policies in accordance with R.N.A.B.C. recommendations. C.U. & C. Health Plan in operation. Room & board in comfortable nurses' residence $40. Situated on the Pacific Coast near several bathing beaches. Apply: Tofino General Hospital, Tofino, V.I., British Columbia.

General Duty Nurses for modern 154-bed General Hospital. Basic salary $285, generous personnel policies, nurses' residence. Apply to: Director of Nurses, Trail-Tadanac Hospital. Trail, British Columbia.

General Duty Nurses: starting salary $299 if 2 yr. experience, $285-$342 in 4 yr. Non registered $270. Maintenance $50, 10 statutory holidays, 4-wk. annual vacation. 1½ day sick leave per mo. very active town, world famous Cariboo cattle country, annual stampede. Apply: Director of Nursing, War Memorial Hospital, Williams Lake, British Columbia.

General Duty & Operating Room Nurses for 434-bed hospital with training school; 40-hr. wk., statutory holidays. Salary $285-$342. Credit for past experience & postgraduate preparation; annual increments; cumulative sick leave; 28-days annual vacation. B.C. registration required. Apply: Director of Nursing, Royal Columbian Hospital, New Westminster, British Columbia.

Obstetric, Operating Room & General Duty Nurses (Immediately) for new modern 125-bed hospital in central B.C., surrounded by magnificent scenery & excellent sporting opportunities. Starting salary B.C.R.N. $285 plus $14 increment with 2-yr. experience. Modern nurses' residence available. Apply: Nursing Supervisor, Regional Hospital, Prince George, British Columbia.

Operating Room Nurse with postgraduate course for active operating room in General Hospital with School of Nursing. Salary $285 plus increment for experience. Must be eligible for B.C. registration. Apply: Director of Nursing, Royal Inland Hospital, Kamloops, British Columbia.

Male Operating Room Nurses (Registered in British Columbia) ability to carry responsibilities of a circulating nurse essential. Experience preferred. Salary $285-$342; differential for postgraduate work. 40-hr. wk., rotating shifts, no "call" work; 4-wk. annual vacation, cumulative sick time, health plan. Apply to: Director of Nursing, Royal Columbian Hospital, New Westminster, British Columbia.

Graduate Nurses for 70-bed acute General Hospital on Pacific Coast. Starting salary $275 with regular increases. Board & room $25 per mo., 5-day wk., 28 days vacation plus 10 statutory holidays. Apply: Matron, St. George's Hospital, Alert Bay, British Columbia.

Graduate Nurses for 60-bed modern hospital in resort area on Vancouver Island. R.N. basic $285 with yearly increments according to RNABC personnel policies. Enquiries: Director of Nursing, Campbell River & District General Hospital, Campbell River, British Columbia.

Graduate Nurse for 31-bed hospital, salary $275 per mo., **B.C. Registered Nurses** $285, with 4 annual increments of $14, 40-hr. wk., 4-wk. vacation, 1½-days sick leave per mo., Lodging $11 per mo. Fare from Vancouver refunded after 6-mo. For personnel policies & information apply to: Administrator, General Hospital, Ocean Falls, British Columbia.

Day Supervisor for new 100-bed south eastern B.C. Hospital. R.N.A. contract personnel policies. Staff residence. Apply: Director of Nursing, K.L.G. Hospital, Nelson, British Columbia.

MANITOBA

Registered Nurse (1-Immediately) for 11-bed hospital. Salary $310 per mo. with increments, less $45 per mo. full maintenance, living quarters in hospital. Apply to: Birch River Hospital Unit, Birch River, Manitoba.

U.S.A.

Registered Nurses for General Duty, obstetrics, operating room & emergency. Beginning salary: $330 per mo. $10 differential paid for afternoon & night shifts, also for obstetrics, nursery & operating room. 40-hr. wk. Liberal vacation policy, sick leave, holidays. Paid health & life insurance. Please write: Mrs. Doretha Stuart, Personnel Director, Community Hospital, Fresno 15, California.

Registered Nurses (2) for small modern hospital situated in the Whiteshell district of Manitoba. Excellent bus & train services to Winnipeg & Kenora. **One (1) Registered Nurse preferably with O.R. experience.** Starting salary $295 with semi-annual increases of $5.00, 1-mo. vacation after 1-yr., 8-statutory holidays. Apply: Matron, District Hospital, Whitemouth, Manitoba.

NOVA SCOTIA

Registered Nurses for Floor Duty (Immediately) 40-hr. wk. Nova Scotia R.N.A. salary scale. Apply to: Superintendent of Nursing, Western Kings Memorial Hospital, Berwick, Nova Scotia.

General Duty Nurses (Immediately). Good personnel policies. Apply: Superintendent, Queens General Hospital, Liverpool, Nova Scotia.

General Duty Nurses for modern 35-bed hospital situated on beautiful South Shore. Good personnel policies. Excellent living quarters. Apply Superintendent, Fishermen's Memorial Hospital, Lunenburg, Nova Scotia.

ONTARIO

Director of Nursing Service for modern 100-bed hospital, day duty only, salary open, excellent personnel policies. Interview will be arranged. Forward enquiries to: Director of Nursing, St. Vincent de Paul Hospital, Brockville, Ontario.

Supervisor of Nursing for modern 42-bed hospital. Residence accommodation available. State experience & salary requested. Direct enquiries to: The Administrator, General Hospital, P.O. Box 909, Sioux Lookout, Ontario.

Supervisor & Public Health Nurses for general program. Supervisor's salary ceiling at present $5,300 per annum & Staff Nursing salary ceiling at present $4,300 per annum. Initial salary dependent on experience. Usual fringe benefits, vacation & sick leave, car allowance etc. Apply: Dr. J. R. Mayers, Director, Norfolk County Health Unit, 58 Peel Street, Simcoe, Ontario.

Clinical (Teaching) Supervisor for Operating Room: postgraduate study essential; previous teaching experience desirable; duties to include staff orientation & in-service education; an interesting position for a progressive person; attractive personnel policies; salary in accordance with preparation & experience. Apply: Director of Nursing, The Doctors Hospital, 45 Brunswick Avenue, Toronto 4, Ontario.

Medical-surgical Clinical Teacher (1). Apply: Director of Nursing, Hotel Dieu Hospital, Kingston, Ontario.

Assistant Superintendent, Registered Nurse for 73-bed General Hospital. Salary depending upon experience & qualifications. Residence accommodation available. Apply to: Superintendent, General Hospital, Kenora, Ontario.

Instructor for Certified Nursing Assistant Course. Training program is 10-months. 100-bed modern hospital. **Dietitian** for 100-bed modern hospital. Excellent personnel policies & salary scale, pension plan. **Physiotherapist** for 100-bed modern hospital. Duties to commence September 1, 1960. Apply to: Sister Superior, St. Vincent de Paul Hospital, Brockville, Ontario.

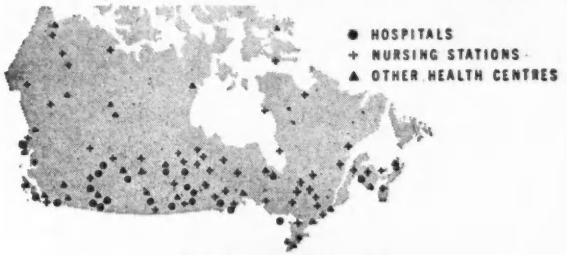
Instructors for Medical-Surgical Nursing, & Nursing Arts, in school of nursing, with new facilities opened this year. Apply to: Director of Nursing, General Hospital, Belleville, Ontario.

Head Nurse for Newborn Nursery in modern department; postgraduate experience desirable, but previous experience would be considered. Attractive personnel policies. Salary in accordance with qualifications. Apply: Director of Nursing, The Doctors Hospital, 45 Brunswick Avenue, Toronto 4, Ontario.

Registered Nurses for expanding General Hospital, Medical, Surgical. Operating Room & Obstetrical services, at Ajax on Highway 401, 20-mi. east of Toronto, hourly bus service to hospital. R.N.A.O. salary schedule, increments every 6-mo., sick & vacation time after 6-mo., 37½-hr. work wk., pension plan, living in accommodation Apply to: Director of Nursing, Ajax & Pickering General Hospital, Ajax, Ontario. **Nurses from Europe & United Kingdom** apply to: Canadian Department of Labor, 61 Green Street, London, W.1, England

Registered Nurse to take charge of new operating room — also **General Duty Nurses** for modern 55-bed hospital, situated in Bruce County, town of 3,000 people, on the shores of Lake Huron. Accommodation available in nurses' residence. Excellent recreational facilities, & all churches represented. Apply to: Superintendent, General Hospital, Kincardine, Ontario.

NURSING WITH INDIAN AND NORTHERN HEALTH SERVICES



OPPORTUNITIES

REGISTERED HOSPITAL NURSES, PUBLIC HEALTH NURSES, AND CERTIFIED AUXILIARY NURSES

for Hospital Positions and Public Health Positions in Outpost Nursing Stations, Health Centres and Field Positions in the Provinces, Eastern Arctic, Northwest Territories and the Yukon Territory.

SALARIES

(1) Public Health Nursing Supervisors: up to $5,460 depending upon qualifications and location.

(2) Directors of Nursing in Hospitals: up to $5,400 depending upon qualifications and location.

(3) Public Health Staff Nurses: up to $4,050 per year depending upon qualifications and location.

(4) Hospital Staff Nurses: up to $3,750 per year depending upon qualifications and location.

(5) Certified Nursing Assistants or Licensed Practical Nurses: up to $200 per month depending upon qualifications and location.

• Room, Board and Laundry in residence at reasonable rates. Statutory holidays. Three week's annual leave with pay. Generous sick leave credits. Hospital-Medical and superannuation plans available.

• Special pay and leave allowances for those posted to isolated areas

For interesting challenging, satisfying work apply to — Indian and Northern Health Services at one of the following addresses:

(1) Regional Superintendent, 4824 Fraser Street, Vancouver, B.C.

(2) Regional Superintendent, 11412-128th Street, Edmonton, Alberta.

(3) Regional Superintendent, 735 Motherwell Building, Regina, Saskatchewan.

(4) Regional Superintendent, 803-9 Confederation Life Building, 457 Main Street, Winnipeg, Manitoba.

(5) Regional Superintendent, 4th Floor, Booth Building, 165 Sparks Street, Ottawa, Ontario.

(6) Zone Supervisor of Nursing, Box 493, North Bay, Ontario.

(7) Zone Superintendent of Indian Health Services, P.O. Box 430, Upper Town, 3 Buade Street, Quebec, 4, P.Q.

(or) Chief Personnel Division,

Department of National Health and Welfare, Ottawa, Ontario.

Registered Nurses & Certified Nursing Assistants for immediate & future vacancies in modern 42-bed hospital. Starting salary $265 & $180 respectively, plus shift allowances. Excellent personnel policies. Apply: Superintendent of Nurses, New Liskeard & District Hospital, New Liskeard, Ontario.

Registered Nurses & Certified Nursing Assistants for 160-bed hospital. Starting salary $265 & $185 respectively with regular annual increments for both. Excellent personnel policies including 5-day wk. & residence accommodation available. Assistance with transportation can be arranged. Apply: Superintendent, Kirkland & District Hospital, Kirkland Lake, Ontario.

Registered Nurses & Certified Nursing Assistants for well equipped 60-bed hospital in small, friendly community on main line of C.P.R. Liberal personnel policies with salaries above R.N.A.O. recommendations. Attractive living accommodations available. Apply: Director of Nursing, Lady Minto Hospital, Chapleau, Ontario.

Registered Nurses ($255 - $285) & **Certified Nursing Assistants** ($185 - $215) for modern 90-bed General Hospital in attractive town near Toronto & resort areas. Annual increments, accumulative sick leave, pension plan, shift differential, 40-hr. wk. Apply to: Director of Nursing, Dufferin Area Hospital, Orangeville, Ontario.

Registered Nurses for General Duty for 15-bed hospital in Red Lake Area. Duties to commence in July, 1960. Salary $300 per mo., maintenance in new residence $30. 4-wk. vacation after 1-yr., transportation expense 1 way repaid after 6 mo. Apply with full particulars to: The Matron, Margaret Cochenour Memorial Hospital, Cochenour, Ontario.

Registered Nurses, Certified Nursing Assistants for General Duty in a most modern 58-bed hospital (to be increased to 77-bed this yr.). Starting salary: R.N.'s $285 per mo. with consideration for past experience; C.N.A.'s $206 per mo. Single room residence accommodation available. Attractive growing town of 5,500 midway between Winnipeg & Fort William on the main line of the C.P.R. & on the Trans-Canada Highway in the midst of large tourist area. For complete information regarding personnel policies, community activities, etc. please write, wire or telephone to: The Director of Nursing, General Hospital, Dryden, Ontario

Registered Nurses for General Duty in all departments including premature & newborn nursery, Isolation, Emergency & Recovery Room. Good salary & personnel policies. Apply, Director of Nursing, Victoria Hospital, London, Ontario.

Registered Nurses for General Duty in modern 18-bed. Private Hospital in iron mining town. 180-mi. north of Sault Ste Marie, Ontario. Excellent accommodation & personnel policies. Starting salary $268 minimum to $303 maximum for experience, less $20 per mo. maintenance. Transportation allowance after 6-mo. service. **Operating Room Nurse,** starting salary $288 minimum with postgraduate course, $323 maximum with 3-yr. experience or more. Apply: Superintendent, Miss O. Keswick, Lady Dunn Hospital, Wawa, Ontario.

Registered Nurses for General Staff & Operating Room in modern hospital (opened in 1956). Situated in the Nickel Capital of the world, pop. 50,000. **Salary: $270 per mo.** with annual merit increments, **plus annual bonus plan,** 40-hr. wk. Recognition for experience. Good personnel policies. Assistance with transportation can be arranged. Apply Director of Nursing, Memorial Hospital, **Sudbury,** Ontario.

Registered Nurses for Staff Duty & Operating Rooms in General Hospital. Modern wings increasing to 64-beds to be opened this summer. Good salary & personnel policies. Apply to: Director of Nursing, Arnprior & District Memorial Hospital, Arnprior, Ontario.

Registered Nurses or Graduate Nurses for General Duty in modern 100-bed hospital. Basic salary $250 for R.N. 40-hr. wk. good personnel policies. Apply: Superintendent of Nurses, Smiths Falls Public Hospital, Smiths Falls, Ontario.

Registered General Duty Nurses (Immediately) for 29-bed hospital. Salary: $265 per mo. with increments up to $295. 4-wk. vacation with pay after 1-yr. service. 8 statutory holidays. Nicely furnished nurses' residence. Apply: Superintendent, Bingham Memorial Hospital, Matheson, Ontario.

Registered General Duty Nurses (all departments) in new 300-bed hospital in Niagara Peninsula. Starting salary $270 with 3-annual increments to $300 per mo., 40-hr. 5-day wk., with 3-wk. annual vacation, residence accommodation available. Apply to: Director of Nursing, County General Hospital, Welland, Ontario.

Registered Staff Nurses for all departments (including Operating Room); 5-day wk.; 8 statutory holidays; 3-wk. vacation annually; starting salary $270 per mo., 3 annual increments; rotating hours of duty. For further information apply to: Director of Nursing, The Doctors Hospital, 45 Brunswick Avenue, Toronto, Ontario.

General Duty Registered Nurses & Certified Nursing Assistants for 73-bed General Hospital on Lake of the Woods. Starting salary for nurses currently registered in Ontario $275-$305 for Nursing Assistants holding Ontario certificate $190-$220, full maintenance $50 monthly. Apply to: Superintendent, General Hospital, Kenora, Ontario.

General Duty Nurses (Immediately) for 30-bed hospital. Reply stating experience & salary expected. Reply to: Secretary, Englehart & District Hospital Board, Englehart, Ontario.

General Duty Nurses for an accredited 64-bed hospital. Starting salary: $265-$295, Excellent personnel policies, pension plan, residence accommodation. Apply Director of Nursing, Douglas Memorial Hospital, Fort Erie, Ontario.

General Duty Nurses for modern 100-bed hospital with building program just completed. Registered start at $260 monthly, Graduates at $225; 40-hr. wk., benefits include accident, sickness & life insurance, hospital & medical insurance plans, & O.H.A Pension Plan. Opportunities for O.R. work. Busy hospital located near Point Pelee National Park, short drive from Detroit, Michigan. Apply: Miss Tillett, Director of Nursing Leamington District Memorial Hospital, Leamington, Ontario.

General Duty Nurses for 100-bed hospital, up-to-date facilities in a beautiful location on the shore of Lake Erie. Salary $267 per mo. with recognition for P.G. courses, 40-hr. wk. effective January 1, 1960. Residence available, Apply: Director of Nursing, General Hospital, Port Colborne, Ontario.

General Duty Nurses for 100-bed modern hospital, south-western Ontario, 32-mi. from London. Salary commensurate with experience & ability; basic: $265, max.: $295. Residence accommodation available. Pension plan. Apply giving full particulars to: The Director of Nurses, District Memorial Hospital Tillsonburg, Ontario.

General Duty Nurses for new 35-bed active hospital. Salary $250 for Registered. Full particulars. Apply: Superintendent, Uxbridge Hospital, Uxbridge, Ontario.

General Duty Nurses Male & Female & Certified Nursing Assistants (Immediately) for 86-bed hospital, 40-hr. wk., 8 statutory holidays & other employee benefits. Collingwood is situated on Georgian Bay & is noted as a vacationland with 7-mi. sand beach along with great skiing on the Blue Mountains in winter. For further information apply: Director of Nursing Services, General & Marine Hospital, Collingwood, Ontario.

McKellar General Hospital, Fort William, Ontario has openings in all departments for **General Staff Nurses.** Basic salary $270 per mo., 40-hr. wk. Good personnel policies for other benefits. Residence accommodation available. Apply to: The Director of Nursing.

Public Health Nurse (Qualified) Position open in a completely generalized program. Salary range, pension plan & other personnel policies given on request. Applicant must have car. Apply to: Dr. W. H. Cross, Muskoka District Health Unit, Bracebridge, Ontario.

Public Health Nurses qualified for generalized program. Minimum salary $3,500 with annual increments & allowance made for experienced nurses. Apply to: Supervisor of Nursing, **Fort William & District Health Unit,** 900 Arthur Street, Fort William, Ontario.

Public Health Nurse for generalized program. Minimum salary $3,400, allowance for experience, cumulative sick leave, shared pension, P.S.I. & hospitalization, 5-day wk., 3-wk. vacation, car allowance or staff car, increment $150. Apply to: Dr. G. Q. Sutherland, M.O.H. City Hall, Guelph, Ontario.

Public Health Nurse for generalized program. Salary $3,500 - $4,375 over a 5 year period, pension plan, P.S.I. Apply: Mr. D. T. McLeod, Secretary-Treasurer, District of Kenora Health Unit, Box 174, Kenora, Ontario.

Public Health Nurses qualified for a generalized program in the City of Oshawa. Salary range $3,500 - $4,370; annual increment $175; starting salary based on experience. 5-day wk., 4-wk. vacation, pension plan, group insurance, hospitalization & P.S.I. employer shared. Transportation provided. Apply: Dr. C. C. Stewart, Medical Officer of Health, 50 Centre Street, City Hall, City of Oshawa, Oshawa, Ontario.

Public Health Nurses Qualified, generalized program, salary range $3,500 - $5,000, good personnel policies. Apply to: The Director, Ontario County Health Unit, Pickering, Ontario.

Public Health Nurses for generalized Public Health Nursing Service, hospital plan, hospital P.S.I., pension plan, sick leave accumulative at the rate of 1½-days monthly, vacation 4-wks. a year, allowance for use of own car. Salary ceiling at present $4,300, initial salary dependent on experience. Apply to: Dr. J .R. Mayers, M.O.H & Director, Norfolk County Health Unit, 58 Peel Street, Simcoe, Ontario.

Public Health Nurses for Staff positions. Starting salary $3,600 with uniform allowance & annual increments. Good personnel policies. Apply to: Miss Helen Saunders, Director, Victorian Order of Nurses, Windsor, Ontario.

Operating Room Nurses for general operating room work which includes cardiovascular, neurosurgery, genito-urinary, Ear, Eye, Nose & Throat & orthopedic surgery. Good salary & personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario.

P.E.I.

General Duty Staff Nurses for 12-bed hospital, 8-hr. shifts, 44-hr.-wk., room & board provided. Apply to: Superintendent, Stewart Memorial Health Centre, Tyne Valley, Prince Edward Island.

BERMUDA

Assistant Matron with postgraduate, or experience in administration nursing service, for 140-bed hospital with building program in operation. For further information apply: Matron, King Edward VII Memorial Hospital, Bermuda.

Registered Nurses. Excellent opportunities in **Private Nursing** are available in Bermuda. Rates similar to those in effect in Province of Quebec. For information regarding openings write to Matron, King Edward VII Memorial Hospital, Bermuda.

Registered Nurses for General Duty Staff. Salary commences at £46-0-0 per mo. with full maintenance. Transportation allowance. For full particulars apply Matron, King Edward VII Memorial Hospital, Bermuda.

Registered Nurses for Operating Room with operating room postgraduate course and/or experience, for 140-bed hospital. Travel allowance paid. For particulars, write Matron, King Edward VII Memorial Hospital, Bermuda.

QUEBEC

Matron (preferably bilingual) for July for newly constructed modern 23-bed General Hospital located at Murdochville. Duties to include supervision of personnel & general hospital maintenance. Excellent recreation facilities including indoor swimming & artificial ice. Three (3) churches. Reply stating age, experience & training to Box No. L, The Canadian Nurse Journal, 1522 Sherbrooke Street West, Montreal 25, Quebec.

Science Instructor for modern 150-bed hospital school 60-70 students. A.N.P.Q. salary scale in operation. Apply: Director of Nurses, Jeffery Hale's Hospital, Quebec City.

Assistant Head Nurses; excellent personnel policies. Apply Director, Shriners' Hospital for Crippled Children, 1529 Cedar Avenue, Montreal, Quebec.

Registered Laboratory Technician for new modern 24-bed hospital located in centre of Gaspe Peninsula, excellent recreation facilities including indoor swimming & artificial ice. Salary commensurate with qualifications. Reply stating training & experience to: Box L, The Canadian Nurse Journal, 1522 Sherbrooke Street west, Montreal 25, Quebec.

Registered General Duty Nurses for 28-bed General Hospital, 45-mi. from centre of Montreal with excellent bus service. Gross salary $250 with full maintenance in nurses' home at $35; 3 increases at 6-mo. intervals to $265; 44-hr. wk., 8-hr. rotating shifts; 1-mo. annual vacation; 7 statutory holidays: 2-wk. sick leave, Blue Cross paid. Apply: Mrs. D. Hawley, R.N., County Hospital, Huntingdon, Quebec.

General Duty Nurse for new modern 24-bed hospital located in centre of Gaspe Peninsula to be opened in August. Working conditions in accordance with Quebec Association of Nurses standards. 44-hr. wk., excellent recreation facilities including indoor swimming & artificial ice. Reply stating training & experience to Box L, the Canadian Nurse Journal, 1522 Sherbrooke Street West, Montreal 25, Quebec.

SASKATCHEWAN

Matron — Superintendent Female (Permanent position, duties to commence as soon as possible) for modern 26-bed hospital in northern Saskatchewan. Starting salary $400 per mo. less $30 per mo. for room & board in a separate residence. 1-mo. annual vacation. Air transportation from Prince Albert or Edmonton & return, once a year, paid by the employer. Apply giving full details of qualifications (age, education, experience & references, etc.) to the: Manager, Municipal Corporation, Uranium City, Saskatchewan.

Matron (1); Registered Nurses for General Duty (2) for 8-bed hospital at Hodgeville, Sask. Duties to commence immediately. Salary & all benefits according to SRNA. Maintenance available at $30 per mo. Contact: Mrs. M. Rumpel, Secretary, Union Hospital, Hodgeville, Saskatchewan.

Matron & Graduate Nurse (1) highest salary paid, 1-mo. vacation with pay after years service, sick benefits, maintenance supplied. If interested apply to: A. J. Hammel, Secretary, Union Hospital, Prelate, Saskatchewan.

Registered Nurses for Fort Qu'Appelle Sanatorium. Initial salary: $280 per mo. with semi-annual increments. Recognition for experience. 40-hr. wk., 4-wk. paid annual vacation, 10 statutory days. Sick benefits & superannuation plans in effect. Room, board & laundry $37.50 per mo. Apply: Superintendent of Nurses, Fort San, Saskatchewan.

Graduate Nurse (1) for 8-bed hospital in southern Saskatchewan. Starting salary $280 less $35 maintenance. 40-hr. work wk., 3-wk. vacation, plus statutory holidays. Apply to: Mrs. D. L. Knops, Secretary-Treasurer, Union Hospital, Rockglen, Saskatchewan.

U.S.A.

Supervisors & Nurses for 80-bed County Hospital. Starting salary $337 - $395 plus normal increases, 3-wk. vacation. Situated in picturesque mountain foothills. No smog or rain, leisurely living in home-like congeniality. Near Los Angeles, San Diego, Las Vegas & 8-mi. from historic Mexico. Send for descriptive letter. Mr. L. J. Lonni, Imperial County Hospital, Box 1771, El Centro, California.

Registered Nurses for modern 374-bed JCAH fully accredited General Hospital. Located on beautiful San Francisco Peninsula, 20-min. drive from the heart of the city. Openings in all services. Excellent personnel policies. Many extra benefits & opportunities for advancement. Top salaries. Apply: Personnel Director, Peninsula Hospital, 1783 El Camino Real, Burlingame, California.

Registered Nurses, (eligible for California registration) for new 254-bed JCAH approved district hospital, San Francisco Bay area. Positions available in surgery, Gyn. O.B., pediatrics & medicine. **Staff Nurses** entrance salary $345 with range to $385 per mo. Supervisory positions at increased rate. Special area & evening differential paid. Free Blue Cross hospitalization & surgical coverage with liberal personnel policies & fringe benefits. Uniforms laundered free. Excellent modern housing, schools & colleges. Apply: Director of Nursing, Eden Hospital, 20103 Lake Chabot Road, Castro Valley, California.

Registered Nurses General Duty for 230-bed approved teaching hospital, resort city. Salary $330 plus $22.50 shift differential, provision for housing allowance. Apply: Director of Nursing, Cottage Hospital, Santa Barbara, California.

DIRECTOR OF NURSING

REQUIRED FOR

160-bed General Hospital

Please reply giving full particulars, including salary expected, to the:

Administrator
KIRKLAND AND DISTRICT HOSPITAL,
KIRKLAND LAKE, ONTARIO

JEAN TALON HOSPITAL

MONTREAL

REGISTERED NURSES

WANTED

Excellent working conditions: pension plan, salary range $57 - $80 per week according to qualifications. Statutory holidays, paid sick leave, paid vacation, life insurance, sickness insurance. Free: 1 meal daily, laundering of uniforms.

For further information write to:

LA DIRECTRICE DU NURSING
HOPITAL JEAN-TALON
1385 EST, RUE JEAN-TALON
MONTREAL 35

REGISTERED NURSES

required for the

GENERAL STAFF

of the

OPERATING ROOM

Salary range $270 - $305

commensurate with experience and qualifications.

Apply

DIRECTOR OF NURSING
McKELLAR GENERAL HOSPITAL
FORT WILLIAM, ONTARIO

OPERATING ROOM TECHNICIANS

THE MONTREAL GENERAL HOSPITAL

would welcome applications for operating room technicians

Please apply to:

THE DIRECTOR OF NURSING,
THE MONTREAL GENERAL HOSPITAL,
1650 CEDAR AVE.,
MONTREAL, QUEBEC.

Registered Nurses for 440-bed modern, progressive hospital. Starting salary $355 per mo. $25 P.M. & night differential. $25 additional for surgery. Tenure salary increases. Liberal vacation plan. 7 pd. holidays, 40-hr. wk. Social security, hospitalization insurance & retirement program Write: Personnel Office, Sutter Community Hospitals, 2820-L Street, Sacramento, California.

Registered Nurses for Operating Room, Delivery, Nursery — all shifts. Starting salary $340 per mo., liberal shift differential, 9 paid holidays, insurance, sick leave & vacation. Contact: Director of Nurses, Washington Township Hospital, 2000 Mowry Avenue, Fremont, California.

General Duty Nurses for large teaching hospital in central California. In-service educational program, college community, good fringe benefits. Salary range $341-$413. Apply: Personnel Director, 732 East Main St., Stockton 2, California.

Staff Nurses for new modern 800-bed General & Tuberculosis Institution in beautiful San Joaquin Valley city — no smog — no snow — 235,000 in metro. area, midway between Los Angeles & San Francisco, close to 3 National Parks, 2 colleges & other cultural advantages. Full maintenance available. Immediate appointment. $341 - $426 mo. Apply immediately to: Director of Personnel, Fresno County Civil Service, Room 101, Hall of Records Building, Fresno 21, California.

Staff Nurses for 300-bed General Hospital. Attractive personnel policies plus differential for specialties, afternoon & night duty. Opportunities for advanced education. Apply to: Director of Nursing Service, Kaiser Foundation Hospital, Oakland 11, California.

Operating Room Nurses: Salary $340 - $385 upon registration plus $33 shift differential. Time & a half (1½) for weekends & holidays. Employee's Health & pension Plans, nurses' residence. Apply: Director of Nursing, Cedars of Lebanon Hospital, Hollywood 29, California.

General Duty Nurses for 50-bed General Hospital located in college town in mountainous portion of Colorado. Salary $300 per mo. with periodic increases. Fringe benefits include meals, uniform laundry, sick leave & vacation. Registration requires 3-mo. training in Psychiatry & Pediatrics on a segregated service. Contact: Superintendent, Community Hospital, Alamosa, Colorado.

Registered General Duty Nurses for 154-bed General Hospital with expansion program under way. Along the shores of Lake Michigan, 25 mi. from Chicago. Salary: $365 for days, $395 for evenings, $385 for nights, 5 day wk. Good personnel policies. Apply Personnel Director, Highland Park Hospital Foundation, 718 Glenview Ave., Highland Park, Ill.

Graduate Staff Nurses (Opportunities in the United States) for well equipped 426-bed non-sectarian General Hospital affiliated with Medical School. Monthly salary rates: $370-$400 days; & $400-$430 afternoon & nights, 40-hr. wk., comfortable, low cost living accommodations in residence. Write to: Director of Nursing Service, Dept. C.J.N., Mount Sinai Medical Center, 2750 West 15th. Place, Chicago 8, Illinois.

Operating Room Nurses (Days & P.M.) 154-bed General Hospital located in beautiful residential suburb along the north shore of Lake Michigan just north of Chicago. Modern ranch style nurses' homes with attractively furnished private bedrooms. 40-hr. wk. Salary: $390 days, $420 evenings, other employee benefits. Contact: Personnel Director, Highland Park Hospital Foundation, Highland Park, Illinois.

Nurses in obstetrics, pediatrics, medicine & surgical nursing. We invite inquiries from all Canadian Nurses considering employment in the United States. For full particulars, write: Director of Nursing Service, Indiana University Medical Center, 1100 West Michigan Street, Indianapolis 7, Indiana.

Registered Nurses (Staff Nurse positions available). Starting salary $300 - $450 per mo., liberal vacation, low cost hospitalization plan, group life insurance, sick leave & other benefits. Opportunity to gain clinical experience in psychiatric nursing; orientation, in-service training & other learning experiences offered during the year. Apply: Director of Nursing Service, The C. F. Menninger Memorial Hospital, Box 829, Topeka, Kansas.

Registered Nurses — Salary open, commensurate with experience, differential for evenings & night service. Openings in Obstetrical & Medical-Surgical areas. Must be eligible for registration in the State of Michigan. Apply to: Personnel Department, Woman's Hospital, 432 E. Hancock Avenue, Detroit 1, Michigan.

Registered Nurse — Immediate positions available in medical-surgical, obstetrical, pediatrics & operating room units of modern, non-profit, J.C.A.H. accredited 125-bed General Hospital located in beautiful suburban area just 20-min. from downtown Detroit. Progressive, expanding organization with liberal personnel policies & in-service education program. Salary commensurate with experience with differential for afternoon & evening shifts. Apply: Director of Nursing, The Lynn Hospital, Lincoln Park, Michigan.

School Nurse for small infirmary in girls' private school, 20-mi. from New York City., pleasant opportunity. Apply: P.O. Box 308, Summit, New Jersey.

Registered Nurses: Transportation Paid via 1st class air to Albuquerque & return in exchange for 1-yr. employment contract. Come to New Mexico, "Land of Enchantment", largest private hospital in state - General Hospital, sanatorium & geriatric units, building program, in-service education. Vacancies for staff duty, no rotation of shift, salary $300/mo. to start, $15 differential for evenings & nights. Write or call: Mrs. Emily J. Tuttle, Director of Nursing, Presbyterian Hospital Center, 1012 Gold Avenue, S.E., Albuquerque, New Mexico, Phone Chapel 3-5611.

Graduate Nurses for 450-bed non-sectarian acute General Hospital with NLN fully accredited school of nursing. Liberal personnel policies include tuition aid for study at Western Reserve University. Opening of new main building has created attractive positions for Staff Nurses in medical, surgical, obstetric & pediatric divisions. Apartments available in immediate neighborhood. Apply: Miss Louise Harrison, Director of Nursing Service, Mount Sinai Hospital, 1800 East 105th. Street, Cleveland 6, Ohio.

Staff Nurses (All Services) for air-conditioned teaching hospital. Base salary — rotation: $292 per mo.; evenings or night: $305 per mo. Good personnel policies. Apply: Director Nursing Service, University of Texas Medical Branch, Galveston, Texas.

Staff Nurses for 200-bed General Hospital; heart of Los Angeles cultural & educational center. **General Duty:** $335 per mo. minimum-days. $25 dif. for 3-11 & $20 dif. for 11-7. Time & ½ over 40-hr. wk. Soc. Sec., State Dis. Ins. 2-wk. vacation end of 1-yr. 3-wk. after 5-yr. 7 paid holidays 12 day sick leave. Cotton uniforms laundered. Nurses' residence $10 per mo. Graduates of accredited schools, California license obtainable immediately. Promotions made from staff whenever feasible. Apply: Mildred Croddy, R.N., Director of Nurses, Santa Fe Coast Lines Hospital, 610 South, St. Louis Street, Los Angeles 23, California.

ALBERTA

Public Health Nurses (2) Those with Public Health qualifications given preference but R.N. considered. Starting salary according to experience & qualifications. Minimum, with P.H. (N) Certificate $3,300; without P.H. (N) Certificate $3,000; annual increments $120, free transport, uniform allowances. For further particulars apply to: Medical Officer of Health, Health Unit, Athabasca, Alberta.

Director of Nursing (Duties to commence as soon as possible) for modern 750-bed accredited civic General Hospital (200-bed addition being built). Responsible position. To plan & direct education & service programs. Perquisites include suite with service, pension plan, 4-wk. vacation, sick benefits. Salary: $7,000 - $9,000 annually depending on qualifications & experience. Address replies to Chairman, Calgary Hospitals Board, General Hospital, Calgary, Alberta.

Associate Director of Nursing (Duties to commence as soon as possible) for modern 750-bed accredited civic General Hospital (200-bed addition being built). Salary range: $5,000 - $6,500 per yr. depending on qualifications & experience. Liberal benefits & personnel policies. Address replies to: Administrator, General Hospital, Calgary, Alberta.

MANITOBA

Registered Nurse (Immediately) for 10-bed hospital in northern mining town. Starting salary $300 per mo., with semi-annual increments. Full maintenance & laundry $40 per mo., 4 nurses on staff, fare paid after 6-mo. employment. Health plan available, 21-days vacation annually with pay. Apply with particulars to: Dr. A. Marrack, Snow Lake, Manitoba.

ONTARIO

Public Health Nurse for generalized program with the Bruce County Health Unit. Pension, surgical-medical, group insurance & cumulative sick leave plans available, 4-wk. vacation, car provided if required. Apply to: T. H. Alton, Secretary-Treasurer, Bruce County Health Unit, P.O. Box 70, Walkerton, Ontario.

Registered Nurses & Certified Nursing Assistants needed to open new 165-bed wing in a 365-bed General Hospital located in suburban Toronto. Good salary, personnel policies include 5-day work wk., 8 statutory holidays. R.N. vacation after 1-yr. - 3-wks. Cert. N.A. - 2-wks. Living-in accommodation. Apply to: Director of Nursing, General Hospital, Scarborough, Ontario.

Registered Laboratory Technician for new 58-bed hospital with new equipment in laboratory. Apply to: The Superintendent, Prince Edward County Memorial Hospital, Picton, Ontario.

Graduate Nurses, Certified Nursing Assistants for General Duty for new 58-bed hospital. For information please write to: Superintendent, Prince Edward County Memorial Hospital, Picton, Ontario.

ALBERTA

General Duty Nurses (2) Salary $270 - $300 per mo. plus other benefits, 40-hr. wk., train fare from any point in Canada will be refunded if employed for 1-year. For full particulars apply to: Municipal Hospital, Two Hills, Alberta. Phone 335.

BRITISH COLUMBIA

Clinical Instructor (Medicine) for school of nursing in interior of British Columbia. Postgraduate preparation required, experience preferable. B.C. registration required. Salary based on preparation and/or experience. Position available **September 1st., 1960.** Apply: Director of Nursing, Royal Inland Hospital, Kamloops, British Columbia.

Operating Room Nurses with postgraduate and/or experience, for 600-bed hospital, salary based on experience and qualifications. Apply to: Director of Nursing, St. Paul's Hospital, Vancouver, British Columbia.

ONTARIO

Instructors (Science & Psychiatry) also Head Nurse for delivery room & General Duty Nurses for operating room in 285-bed hospital. 40-hr. wk., 8 statutory holidays, 3-wks. vacation, sick time. For further information, apply: Director of Nursing, Wellesley Hospital, 160 Wellesley Street, East, Toronto 5, Ontario.

BRITISH COLUMBIA

General Duty Nurses Salary $285 per mo., increase of $12 after 1-yr. service. Charge for room, board & laundry $40; all statutory holidays paid, 28-days vacation after year's service. Graduate complement six (6). Apply: Matron, Slocan Community Hospital, New Denver, British Columbia.

Graduate Nurses (2) for 21-bed United Church Mission Hospital. For Information regarding salary & personnel policies, kindly write to: The Matron, Queen Charlotte Islands General Hospital, Queen Charlotte City, British Columbia.

MANITOBA

Registered Nurses for Swan River Valley Hospital. Salary $280 with 4 semi-annual increments to $300, 40-hr. wk., 3, 8-hr. rotating shifts, 3-wk. vacation after 1-yr. continuous employment, 4-wk. thereafter. Recreational facilities include golfing, fishing, swimming, curling, etc. Apply to: Swan River Valley Hospital, Swan River, Manitoba.

NOVA SCOTIA

Graduate General Duty Nurses (2) Operating Room Nurse (1) for small hospital in beautiful Annapolis Valley. For further information, please contact: Superintendent, Annapolis General Hospital, Annapolis Royal, Nova Scotia.

SASKATCHEWAN

Matron: General Duty Nurse (1) immediately for 9-bed hospital. Salary $315 & $290 respectively, increments, 40-hr. wk., 12-days sick leave, 3-wk. vacation after 1-year service, uniforms laundered, room $10 & meals 25¢. Apply to: D. J. Wiley, Secretary-Treasurer, Saltscoats & District War Memorial Hospital, Saltcoats, Saskatchewan.

ALBERTA

Nurses for General Duty (2) in 29-bed hospital near summer resort. Salary $270 per mo. Excellent residence. Apply: Matron, Municipal Hospital, Eckville, Alberta.

General Duty Nurses — O.R. Nurses with postgraduate or equivalent for 146-bed General Hospital. Personnel policies in accordance with B.C.R.N.A. Rooms available in nurses' residence. **Nurses Aides** — with vocational training. Salary $177-$201 per mo. We do not have a residence for our Nurses Aides. Apply to: Director of Nursing, General Hospital, Chilliwack, British Columbia.

Public Health Nurses — opening for bilingual nurse (1) salary range $3,630 - $4,158, liberal benefits. Apply to: Peace River Health Unit No. 21, Peace River, Alberta.

BRITISH COLUMBIA

Registered Nurses for General Duty Nursing (2) in 18-bed hospital located at Nakusp, B.C. Accommodation provided in the hospital. Apply to: The Administrator, Arrow Lakes Hospital, Nakusp, British Columbia.

Registered Nurse for 30-bed hospital, starting salary $285 per mo., rotating shifts with 40-hr. wk., 11 statutory holidays & 1-mo. vacation with pay after 1-yr. service. Pleasant nurses' residence next door to hospital, room and board $40. Address replies to: The Matron, Community Hospital, Grand Forks, British Columbia.

Head Nurse for Medical Ward in General Hospital with school of nursing, located in the interior of B.C. Salary based on experience and/or postgraduate preparation. Apply: Director of Nursing, Royal Inland Hospital, Kamloops, British Columbia.

Registered Nurses (September) for modern active 25-bed hospital on beautiful Lake Windermere in the Canadian Rockies. Excellent recreational facilities all yr. 90-mi. from Banff & Lake Louise. Policies according to RNABC. Basic salary: $285 per mo. Excellent residence accommodation with full maintenance: $50 per mo. Apply: Matron, Windermere District Hospital, Invermere, British Columbia.

ONTARIO

Operating Room Supervisor (fully qualified & experienced) Good salary, 5-day wk., other benefits. Apply to: Mr. F. P. Chaffy, Administrator, The Cottage Hospital, Pembroke, Ontario.

Public Health Nurse (qualified) generalized program, salary $3,400, annual increment $200, 5-day wk., car allowance ten cents per mile, group insurance plan, 4-wk. vacation. Apply to: Dr. W. N. Turpel, M.O.H. & Director, Lennox & Addington County Health Unit, Napanee, Ontario.

Public Health Nurses. Applications are solicited for Simcoe County Health Unit. Personnel policy on request. Write to: Secretary-Treasurer, Court House, Barrie, Ontario.

U.S.A.

Operating Room Supervisor for 230-bed General Acute Hospital, JCA; faculty status with fully accredited NLN school, 50-students. B.S. desired and/or postgraduate study required. Liberal policies, 40-hr. wk. Salary to $6,000 pending professional background. Growing attractive community lake area. 65-mi. NYC. Write: Assistant Administrator, Danbury Hospital, Danbury, Connecticut.

UNIVERSITY HOSPITAL
SASKATOON, SASKATCHEWAN

Requires

General Staff Nurses for Medical, Surgical, Obstetrical and Pediatric Services. Forty hour week. Salary $270 to $310 gross per month. Differential for evening and night duty. Temporary residence accommodation if desired.

Apply to:

DIRECTOR OF NURSING, UNIVERSITY HOSPITAL,
SASKATOON, SASKATCHEWAN

EDUCATIONAL DIRECTOR
FOR NEW SCHOOL OF NURSING

New school building, new student residence. Hospital opened in 1956, all services; 250-beds.

Present plan to enrol first class of students for September 1961. Director required at once to facilitate planning an educational program and arranging for staff.

Opportunities for additional education at Laurentian University.

Salary according to qualifications and experience.

Apply:

DIRECTOR OF NURSING, SUDBURY MEMORIAL HOSPITAL,
REGENT STREET SOUTH, SUDBURY, ONTARIO.

DIRECTOR OF NURSING

Modern hospital 42-adult beds, 11-bassinets, located in a company operated town & serves a population of approximately 6,000. Salary range from $357 - $477 per mo., commensurate with experience & qualifications. Community organized recreation, residence accommodation & all conventional benefits available.

Apply giving full particulars of training & experience to:

ADMINISTRATOR, ANSON GENERAL HOSPITAL,
IROQUOIS FALLS, ONTARIO.

TOWNSHIP OF NORTH YORK
(METROPOLITAN TORONTO AREA)

requires

PUBLIC HEALTH NURSES

Permanent appointments. 5 day, 35 hour week. Excellent employee benefits. Car Allowance. Duties to commence August or September 1st. Population of Municipality 240,000.

Salary range: $73.86 - $77.16 - $80.47 - $84.87. (Allowance granted for experience).

Applications or enquiries may be addressed to:

DR. C. E. HILL, MEDICAL OFFICER OF HEALTH, TOWNSHIP OF NORTH YORK,
5000 YONGE STREET, WILLOWDALE, ONTARIO.

REGISTERED NURSES
AND
CERTIFIED NURSING ASSISTANTS

REQUIRED FOR

44-bed hospital with expansion program, 40-hr. wk. Situated in the Niagara Peninsula. Transportation assistance.

For salary rates & personnel policies.
APPLY TO: DIRECTOR OF NURSING,
HALDIMAND WAR MEMORIAL HOSPITAL,
DUNNVILLE, ONTARIO

PUBLIC HEALTH NURSE

REQUIRED FOR

a rural urban district in a northwestern Ontario Health Unit. Nurse will live in a city of 45,000 population. Hospital plan, P.S.I., Pension Plan, sick leave 1½ days monthly, 4 weeks vacation, generous car allowance. Salary commensurate with experience.

Apply to:

DR. W. C. MacPHERSON, DIRECTOR
PORT ARTHUR & DISTRICT HEALTH UNIT
93 BALSAM ST., PORT ARTHUR, ONTARIO

REGISTERED NURSES AS FLOOR SUPERVISORS

In Geriatric Institution near New York City. Starting salary $4,300 per annum, 37½-hour week plus fringe benefits totalling $700, includes 4 weeks paid vacation, 12 days paid sick leave, 7 paid holidays, Xmas bonus of 1 week's salary. No deduction for meals, residential accommodations $200 year.

Write:

EXECUTIVE DIRECTOR,
DAUGHTERS OF MIRIAM,
CLIFTON, NEW JERSEY.

THE VANCOUVER GENERAL HOSPITAL

Appointments to nursing positions are available in this medical teaching centre. Vacation relief positions are available with an opportunity to enjoy an excellent summer climate and an attractive social activities program.

B.C. Registration is required with a starting salary of $299 per month for experienced nurses.

Please apply to:

PERSONNEL DEPARTMENT,
10TH AVENUE AND WILLOW STREET,
VANCOUVER 9, BRITISH COLUMBIA.

THE OTTAWA CIVIC HOSPITAL

WITH

A capacity of 1200 beds including
A new modern 300 bed unit

OFFERS

An interesting variety of experiences

Good personnel policies

Salary, allowance for experience and postgraduate courses.

Apply:

DIRECTOR OF NURSING,
OTTAWA CIVIC HOSPITAL,
OTTAWA, ONTARIO.

NURSES

REQUIRED AT

ROSEWAY, HOSPITAL

SHELBURNE, N.S.

Superintendent of Nurses	$4,200 - $4,950
Nursing Supervisor	$3,240 - $3,750
Operating Room Nurse	$3,120 - $3,600
Staff Nurses	$2,880 - $3,360

Full Civil Service benefits.

APPLY TO:

NOVA SCOTIA CIVIL SERVICE COMMISSION
P.O. BOX 943, HALIFAX, NOVA SCOTIA

OPERATING ROOM SUPERVISOR
and
GENERAL DUTY NURSES

for 60-bed General Hospital 22 miles from London, excellent personnel policies, accommodation available in residence.

Apply to:

DIRECTOR OF NURSING,
STRATHROY GENERAL HOSPITAL,
STRATHROY, ONTARIO.

WOODSTOCK GENERAL HOSPITAL

INVITES APPLICATION

for the following positions:

(1) Head Nurse, surgical unit

(2) Head Nurse, medical unit
2 General Staff Nurses for:
(a) Emergency department
(b) Operating room

For further information write:

THE DIRECTOR OF NURSING,
GENERAL HOSPITAL, WOODSTOCK, ONTARIO.

NURSES...

Miss Florence Flores, the Director of Nursing of the Massachusetts Memorial Hospitals, suggests that you note the following benefits.

- √ Choice of Service
- √ Friendly and co-operative supervision
- √ Promotion opportunities
- √ Recreational and cultural facilities
- √ Tuition assistance available

Liberal Benefits include —

- √ 40 hour—5 day week
- √ Liberal sick benefits (accumulative to 8 weeks with pay)
- √ Paid Blue Cross
- √ 9 observed holidays
- √ Close proximity to excellent schools, colleges and universities

Salary Schedules

(Starting salary based on experience & qualifications)

$3,900 to $5,200 per annum Day duty
$4,940 to $6,240 per annum Permanent Evening duty
$4,680 to $5,980 per annum Permanent Night duty

Your are cordially invited to visit our hospital

or

Mail attached form for additional information

Miss Florence Flores, Director of Nursing
The Massachusetts Memorial Hospitals
750 Harrison Avenue, Boston, Mass., U.S.A.

Choice of service .....

Name .....

Address .....

City ..... **Zone** ..... **Prov.** .....

"YOUR CAREER IS OUR CONCERN"